APPENDIX A

HOSPITAL, SURGICAL, MEDICAL,
PRESCRIPTION DRUG AND HEARING AID COVERAGES

I. Definitions

As used herein:

A. "accidental injury" means a bodily injury such as a strain, sprain, abrasion, contusion or other condition which occurs as the result of a traumatic incident such as, but not limited to: ingestion of poison; overdose of medication, whether accidental or intentional; allergic reaction resulting from trauma, such as bee stings or insect bites; inhalation of smoke, carbon monoxide, or fumes; burns, frostbite, sunburn, and sunstroke; and attempted suicide.

B. "ambulance services" means medically necessary transportation and life support services furnished within the Program provisions to sick, injured or incapacitated patients by a licensed ambulance provider meeting Program standards, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

C. "approved" - see "participating"

D. "benefit period" means a period of time during which an enrollee is entitled to receive certain covered services which are subject to Program maximums (see App. A, II.B. and App. B, II.B.). The services which may be subject to maximums include, but are not limited to, inpatient hospital services (with special provisions for pulmonary tuberculosis treatment under this Appendix, and mental health and substance abuse treatment under Appendix B), admissions to skilled nursing facilities (whether under this Appendix or Appendix B), treatment under psychiatric partial hospitalization programs (and substance abuse partial hospitalization programs), substance abuse halfway house programs (under Appendix B) and hospice care.

E. "covered expenses" means the reasonable and customary, preestablished, or contracted charges incurred for covered materials and services, as described in Section III of this Appendix, provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of this Program. Such covered expenses fall in the following areas of coverage or categories of expenses:

1. hospital expenses;

2. skilled nursing facility expenses;

3. physical, speech and functional occupational therapy and cardiac rehabilitation expenses;

4. home health care expenses;

5. medical, surgical expenses;

6. ambulance service expenses;

7. prescription drug expenses;

8. hearing aid expenses;

9. durable medical equipment and prosthetic or orthotic appliance expenses; and

10. hospice expenses.

F. "custodial" or "domiciliary" care or services means the type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical or psychiatric care or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services). Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel, and usually can be provided by aides or other persons withlimited training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toiletting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes and routine skin care. The determination as to the nature of the care is not a function of the setting (e.g., hospital, skilled nursing facility, nursing home, another institutional setting or the patient's home) or of the professional status of the person (e.g., physician, nurse, therapist or aide) rendering the service, but of the severity of the patient's illness and the intensity of services being performed. The carriers or Utilization Review Organization, as appropriate shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's (or Utilization Review Organization's) determination as to the nature of the care being provided shall be given full force and effect unless

it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

G. "domiciliary" - see "custodial"

H. "drugs, biologicals, and solutions" means medicinal agents which are approved for commercial distribution by the Federal Food and Drug Administration and are legally prescribed for the treatment of an illness or injury.

I. "durable medical equipment" means equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to an enrollee in the absence of illness or injury.

J. "freestanding outpatient physical therapy facility" means a facility, separate from a hospital, which provides outpatient physical therapy services. Such facilities must meet Program standards and be approved by the local carrier.

K. "functional occupational therapy" - see "physical therapy"

L. "home health care" means care or services provided in the home for a patient whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/services may be skilled or unskilled in nature.

M. "home health care agency" means a centrally administered agency providing physician-directed nursing and other paramedical services to patients at home. A home health care agency must meet Program standards and be approved by the local carrier.

N. "hospice" means a program of medical and non-medical services provided for terminally ill enrollees and their families through agencies which administer and coordinate the services. A hospice program must meet Program standards and be approved by the local carrier.

O. "hospital" means a facility which provides diagnostic and therapeutic services on a continuous inpatient basis for the surgical, medical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons.

These services are provided by, or under the supervision of, a professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hours-a-day nursing service by registered nurses. A rehabilitation institution shall be considered to be a hospital if the institution is approved as such under this Program. A

hospital must meet all applicable local and state licensure and certification requirements and be accredited as a hospital by state or national medical or hospital authorities or associations.

A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution to which enrollees may be remanded by the judicial system; an institution for the treatment of the aged or substance abusers; or a skilled nursing facility or other nursing care facility. It does not include a health resort, rest home, nursing home, convalescent home, or similar institution.

P. "medical appropriateness" means that the medically necessary service, care, treatment or supply is the type, level and setting considered the most appropriate based on accepted standards of practice in the United States for the patient's condition.

Q. "medical emergency" means a permanent health threatening or disabling condition, other than an accidental injury, which requires immediate medical attention and treatment.

The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the enrollee's health, or place such enrollee's life in jeopardy. The enrollee's signs and symptoms verified by the treating physician at the time of treatment, and not the final diagnosis, must confirm the existence of a threat to the enrollee's life or bodily functions. The carriers shall have authority to construe, interpret and apply this provision of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to be inconsistent with the Program provisions or arbitrary and capricious.

R. "medical necessity" means that the need is present for the services, care, treatment or supplies based on accepted standards of medical practice in the United States for the treatment of any injury, illness or pregnancy. Determinations of the Control Plan or Utilization Review Organization, as appropriate, as to medical necessity and the accepted standards of medical practice are based on factors which include, but are not limited to: scientific data (such as reported controlled studies), information from local and national medical, professional and insurance societies, organizations, committees and bodies; and approvals and policies of the Food and Drug

Administration, the Department of Health and Human Services and other Federal agencies. The Control Plan or Utilization Review Organization, as appropriate, shall have discretionary authority to interpret, apply and construe this provision of the Program. The Control Plan's or the Utilization Review Organization's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

S. "non-physician practitioners" means individuals other than physicians who are legally qualified and licensed to perform certain health care services. The following categories of non-physician practitioners may be eligible for reimbursement for services within their area of expertise. To be eligible for reimbursement, they must meet Program standards (including eligibility for reimbursement by Medicare for Medicare-eligible patients) and be approved by the carrier.

1. "certified registered nurse anesthetist" means a registered nurse trained in the administration of anesthetics.

2. "physical therapist" means an individual trained in the evaluation and rehabilitation of injured or disabled enrollees through non-medical and non-surgical measures.

3. "functional occupational therapist" means an individual trained in the restoration of a specified level of function of injured or disabled enrollees through non-medical and non-surgical measures.

4. "speech therapist" means an individual trained in the correction of speech and language disorders through non-medical and non-surgical measures.

5. "certified nurse mid-wife" means a registered nurse trained to provide obstetrical services who is legally qualified and registered, certified and/or licensed.

T. "orthotic appliance" means an external device intended to correct any defect of form or function of the human body.

U. "participating" or "approved" means any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, or other provider of health care services which, at the time an enrollee receives services included under this Program, has entered into a contract or agreement with a carrier to provide

those health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expense, as determined by the carrier, as payment in full (unless otherwise provided). A physician who is not a participating physician may participate for individual claims.

V. "physical therapy" and/or "functional occupational therapy" mean therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, to the development of new function attainable following surgery, or, if for a chronic or congenital condition, to significantly improve the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

W. "physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services which they are legally qualified to perform.

1. "dentist" means a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention and treatment of diseases of the teeth and related structures. Such services are provided for under the dental coverage (see App. C of the Program). However, certain services of a dentist may be covered under this Appendix when provided in accordance with App. A, III.E.3.a.(2), or when performed in response to a medical diagnosis and when Program standards are met. A dentist also may prescribe medications which may be covered under the prescription drug coverage (see App. A, III.G.).

2. "podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention, and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages (see App. A, III.E.). A podiatrist also may prescribe medications which

may be covered under the prescription drug coverage (see App. A, III.G.).

3. "chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxations or misalignments of the spinal column and related bones and tissues which produce nerve interference. Services of chiropractors which may be covered are limited to diagnostic radiological services (see App. A, III.E.3.j.) and emergency first aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues.

Under this Program, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.

X. "private duty nursing" means care or services provided by a nurse pursuant to a contract with a patient and/or a patient's family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by an institution (such as a hospital or skilled nursing facility) or the part-time/intermittent/skilled care provided by a home health care agency.

Y. "private room" means a room containing one bed.

Z. "Program standards" means criteria established by the Control Plan (and approved by the Corporation) for approval of providers or for benefit payment. At a minimum, providers must meet applicable accreditation, licensing and credentialing requirements and be qualified to render services or furnish materials under this Program. In the case of provider approval, standards also may include, but are not necessarily limited to, such matters as approval for Medicare reimbursement and acceptance of Medicare assignment and/or Program reimbursement as payment in full. In the case of benefit payment, standards may include, but are not necessarily limited to, such matters as the service or item being approved by Medicare and/or the service or item being delivered or prescribed in response to particular diagnoses. Local carriers shall be responsible for establishing whether local providers conform to such standards, or for obtaining approval of exceptions through the Control Plan.

AA. "prosthetic appliance" means an artificial device which replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

BB. "rehabilitation care" means services within an acute care hospital or skilled nursing facility for intensive rehabilitation through a multidisciplinary, coordinated team approach. Such care is provided on an inpatient basis for patients found to have significant functional disability resulting from the recent onset of an acute condition (such as a broken hip or a stroke) or exacerbation of a chronic condition (such as rheumatoid arthritis), where there is a reasonable expectation for significantly increased function as a result of aggressive, inpatient, multi-modality rehabilitation services.

CC. "semiprivate room" means a room containing two beds.

DD. "service" means any care or procedure, as listed and limited herein, which is provided for diagnosis or treatment of disease, injury or pregnancy and which is based on valid medical need according to accepted standards of medical practice. Certain types of care or procedures may be excluded as covered services under this Program.

EE. "skilled nursing care" means care or services which are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury which requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determine whether the service is skilled.

Examples include, but are not limited to: administration of intravenous fluids and medications; suctioning; dressing changes for major post-operative wounds and dressing changes for infected lesions which require irrigation and/or medication and/or sterile dressings; catheterizations; ventilator care; cardio-pulmonary assessments; and colostomy/cystostomy care. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's determination as to the nature of care being provided shall be given full force and effect unless it is determined by the Plan Administrator to have been

inconsistent with Program provisions or arbitrary and capricious.

FF. "skilled nursing facility" means a facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet Program standards and be approved by the local carrier.

GG. "special care unit" means a designated unit within a hospital (such as cardiac care, burn care, or intensive care unit) that concentrates all necessary types of equipment together with skilled nursing and supportive services needed for care of critically ill patients and is recognized as such by the carrier.

HH. "speech therapy" means therapy to restore the functional loss of speech resulting from an organic medical condition.

II. "therapeutic care" means specific and definitive surgical, medical, psychiatric or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance in nature. The carrier's determination as to the nature of the care shall be given full force and effect unless it is determined by the Plan Administrator to have been contrary to the Program provisions or arbitrary and capricious.

JJ. "Utilization Review Organization" means an organization retained to perform certain utilization review and utilization management functions, including but not limited to predetermination, concurrent and retrospective utilization reviews.

II. Terms and Conditions

A. Payment of Benefits

1. Benefits will be payable, subject to the provisions of this Program, when an enrollee incurs a covered expense.

2. Under the Program, benefits for certain covered services are payable only if approved by the carrier and/or if furnished by approved providers, when applicable. If such approval is not obtained, or if such providers are not utilized, benefits for such services may be reduced or eliminated. Examples include, but are not limited to, failure to comply with the predetermination requirements or failure to utilize panel providers.

B. Benefit Period Provisions

1. An enrollee is entitled to a maximum of:

a. 365 days of covered inpatient hospital services for each continuous period of hospital confinement or for successive periods of confinement within a benefit period; however,

(1) the inpatient treatment of pulmonary tuberculosis is limited to 45 days of the benefit period; and

(2) the inpatient treatment of mental disorders and substance abuse (as set forth in Appendix B) is limited to 45 days of the benefit period;

b. 210 days (lifetime maximum) of hospice care; and

c. two days of inpatient skilled nursing facility care for each remaining day of inpatient hospital care within the benefit period, to a maximum of 730 days for each continuous period of confinement or for successive periods of confinement within a benefit period. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. Use of days of care in a skilled nursing facility does not reduce the number of days of inpatient hospital care.

2. Benefit periods for physician services and medical care related to hospital inpatient admissions and skilled nursing facility admissions are related to

or may be determined concurrent with the benefit periods for facility services as noted below:

a. For conditions other than pulmonary tuberculosis, an enrollee is entitled to coverage for medical care for the duration of a hospital or skilled nursing facility admission.

b. Coverage of medical care for pulmonary tuberculosis is limited to 45 days for the treatment of tuberculosis for each continuous period of confinement or for confinements separated by less than 60 days.

3. Benefit periods may be renewed, subject to the following:

a. To be eligible for further benefits under each of the subsections, there must be a separation of 60 days between periods of hospitalization for any reason. For example, if an enrollee's initial inpatient admission for mental health treatment exhausts the 45-day maximum and is separated by 60 days from a second admission for mental health treatment, but the person had been hospitalized for other reasons during the intervening period, the second mental health admission would not be covered.

b. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential substance abuse treatment facility, or any other facility to which the 60-day benefit renewal period applies and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits were paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse day or night care program, a substance abuse halfway house, a hospice program or is receiving home health care services, the 60-day renewal period is broken, whether or not benefits were paid as a consequence of receipt of such services.

C. Access to Information

In order to ensure proper administration and to facilitate the ongoing evaluation of this Program:

1. Enrollees shall authorize providers of services to furnish to the carrier(s), upon request, information relating to services to which the enrollee is, or may be, entitled under this Program.

   Providers of services shall be authorized to permit the carrier(s) to examine their records with respect to the services and to submit reports of the services in the detail requested by the carrier(s). All information related to treatment of the enrollee will remain confidential except for the purpose of determining rights and liabilities arising under this Program, or as otherwise required by law or pursuant to a written authorization by the patient.

2. A provider claiming payment from the carrier must furnish a report to the carrier, in the prescribed form, within 180 days from the date of the last continuous service listed on the report as having been rendered to the enrollee. The provider must certify upon the report that the provider is entitled to payment under this Program and that the service was personally rendered or rendered during the provider's presence and under the provider's supervision. An enrollee's request for service is authorization to the provider to make the report.

3. An enrollee seeking payment from a carrier must furnish, or cause the provider to furnish, a report to the carrier in the form prescribed by the carrier. By filing the report the enrollee consents that the carrier may have access to the data disclosed by the records and files of the provider and of the hospital or other facility named in this report.

D. Identification Cards

1. Enrollees shall be furnished identification cards by the carrier(s). Such cards shall contain toll-free telephone numbers for obtaining predetermination information or other required approvals of services.

2. The identification card must be presented when service is requested.

3. An enrollee shall not use an identification card to obtain benefits to which such enrollee is not entitled, nor shall the enrollee permit another

person to obtain benefits to which such person is not entitled.

E. Medicare

1. Under current Federal laws, certain enrollees otherwise eligible to enroll for benefits under Medicare may defer enrollment in Medicare without penalty. If such enrollees elect to enroll in Medicare, the Program remains the primary source of benefits, with Medicare supplementing Program coverage. For purposes of subsection 2 below, Medicare enrollment of such enrollees shall be disregarded.

2. Coverage under this Program is reduced to the extent that payment is available under Medicare, or to the extent that payment would have been available under Medicare but for the fact that Medicare payment is secondary to coverage provided by a source other than this Program. In the latter event, the maximum liability of this Program will be limited to the balance remaining after the liability of both the primary coverage and Medicare have been determined and benefits paid.

   a. Enrollees who are eligible to enroll for benefits under Part A of Medicare, whether or not they are enrolled, will have all benefits available under this Program reduced to the extent payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefits) under Part A of Medicare. The hospital coverage under this Program will be reduced during the additional Medicare 60-day lifetime maximum for inpatient hospital benefits, to the extent the benefits are available under Medicare whether or not the enrollee uses the lifetime reserve.

   b. Enrollees who are eligible to enroll for benefits under Part B of Medicare, whether or not they are enrolled, will have all benefits available under this Program reduced to the extent that payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefits) under Part B of Medicare.

   c. All benefits furnished under Medicare Part A, or which would have been furnished had the enrollee been enrolled for Medicare Part A

benefits, and all benefits furnished under Medicare Part B will be charged against the maximum benefit periods and maximum benefit amounts under this Program. Reduction of coverage under this provision or charging of Medicare benefits against the maximum benefit periods and maximum benefit amounts of this Program will be limited to the benefits provided by Medicare which would have been provided under this Program in the absence of this subsection.

3. If an enrollee, while covered under the Program, also enrolls for coverage under Part D of Medicare, such enrollee will be ineligible for coverage under the Program for as long as enrollment in Part D continues.

F. Medical Necessity and Appropriateness

1. All covered services under the Program are subject to a requirement of medical necessity (see App. A,I.R.).

2. The Control Plan will establish criteria, where necessary, to define medical necessity and accepted uniform standards of medical practice for the purposes of determining covered services (except as set forth in subsection 4, below). The Control Plan shall propose such criteria to the Corporation, and when such criteria are approved, shall communicate them to the local carriers. Local carriers shall communicate the criteria to providers.

3. Local carriers, or others, requesting establishment, revision or withdrawal of such criteria shall submit such requests to the Control Plan for consideration. The Control Plan shall advise the Corporation of all such requests and recommended decisions.

4. Medical necessity and appropriateness criteria will be established by the Utilization Review Organization for those services which require predetermination.

G. Legal Action by Enrollee

Please refer to Article I, Section 6.

H. Changes in the Program

1. From time to time additional coverages may be provided or existing coverages withdrawn by the

Corporation by action of its Board of Directors or other committee expressly authorized by the Board to take such action.

2. Neither the Control Plan nor a local carrier may make a substantive change to the coverages or benefits without prior approval of the Corporation. This includes amending administrative practices, policies or interpretations that in the judgment of the Corporation would materially affect the benefits of the Program.

I. Approval of New Services, Technologies and Provider Classes

1. A procedure has been established for implementing the addition of services or items not previously covered under this Program.

2. A proposal for the inclusion in the Program of a new or revised service or item may be submitted to the Control Plan by a carrier, a physician or physician group, a professional organization, a provider or provider group, or the Corporation.

3. The Control Plan shall review such proposal and make a written recommendation to the Corporation regarding whether or not the service or item should be added to the Program. Such recommendation shall include, but not be limited to, the following:

   a. Any quality of care concerns and proposed steps to ensure quality delivery of the service if approved;

   b. Any access concerns and proposed actions to resolve such concerns;

   c. Any concerns over appropriate utilization and proposed actions to resolve such concerns;

   d. Any service(s) being replaced by the new service, and a plan for discontinuation of coverage for the replaced service; and

   e. Positive or negative impact on Program costs.

4. The Corporation shall review and approve or disapprove the Control Plan recommendations. If approval is given and the service is added, an effective date will be established. Only services or items provided on or after the effective date will be covered.

5. The Control Plan will advise local carriers and other affected parties of any approved additions to the Program, the effective dates, and/or limitations or special provisions that apply. The local carriers will advise providers.

J. Participating, Nonparticipating and Departicipating Hospitals

1. When an enrollee's Basic Medical Plan (BMP) or Enhanced Medical Plan (EMP) option is administered by a carrier that has participating agreements with hospital providers, covered services provided to such an enrollee by a nonparticipating hospital (i.e., a hospital with which the carrier does not have a participating agreement), or by a departicipated hospital (i.e., a hospital whose participating agreement ceases, whether at the option of the provider, the carrier or both), are payable in accordance with the provisions set forth, respectively, in J.2. and J.3. below.

2. Benefits for covered services provided by a nonparticipating hospital (other than a psychiatric hospital) shall be payable as follows:

a. Upon admission for a non-emergency condition, payment is limited to $230 per day for inpatient room and board charges and $20 per day for inpatient ancillary charges. Benefits are available for the duration of the admission, but in no event beyond the number of days available under the hospital benefit period.

b. For an emergency admission (as defined by the Program):

(1) Benefits will be payable for the reasonable charges (as determined by the carrier) for ground ambulance transfer to the closest participating hospital capable of handling the case, upon approval of the attending physician and the carrier. This approval must be based on the physician's medical certification that the transfer will not endanger the enrollee's health and of carrier certification that the subsequent stay will be of sufficient duration to justify the transfer.

(2) When the enrollee cannot be safely moved to a participating hospital, the enrollee is entitled to benefits during the first five days of the admission, but in no event beyond the number of days available under the hospital benefit period.

(3) Following the first five days of admission, payment is limited as described in 2.a. above. However, if transfer to a participating hospital cannot be arranged, either because such a transfer would endanger the enrollee's health or because the subsequent stay would not be of sufficient duration to justify transfer, benefits are payable for the duration of such admission, but in no event beyond the number of days available under the hospital benefit period.

c. Admissions to psychiatric hospitals are subject to the provisions of Appendix B of the Program.

d. Payment for outpatient services received at a nonparticipating hospital (other than a psychiatric hospital) is limited to $35 for each condition. Effective January 1, 1997, certain covered emergency services received in the outpatient department of a nonparticipating hospital will be paid on the same basis as if in a participating hospital. To qualify for payment, the claim must be for services related to a medical emergency or a serious bodily injury that requires immediate medical attention to avoid placing the enrollee's life in jeopardy, permanent damage to the enrollee's health or significant impairment of bodily functions. Treatment must be provided at the hospital immediately following the medical emergency or the injury. Payment will not exceed the amount that would be paid to a participating hospital, and there can be no assurance that the payment will cover the entire amount billed by the hospital.

3. The carrier will make efforts to notify enrollees of a hospital's departicipation and of the following payment arrangements:

a. For an enrollee whose hospital admission commences prior to, or within 30 days following, the date a participating hospital departicipates, benefits will be paid for the duration of such admission, but in no event beyond the number of days available under the hospital benefit period.

b. For an enrollee whose admission to such hospital commences later than 30 days from the date the hospital departicipates, payment for non-emergency admissions is limited as described in 2.a. above and payment for emergency admissions is limited as described in 2.b. above.

c. For an enrollee admitted to a departicipated hospital that regains participating status within six months of departicipating, the carrier will make payment toward the balance of the hospital's reasonable charges (as determined by the carrier) for covered services incurred by the enrollee during the period of departicipation. The carrier shall also arrange that such payment relieves the enrollee of further financial obligation (other than the enrollee's deductible and/or copayment) with respect to covered services received during the departicipation period, and that any portion of such balance previously paid by the enrollee (other than the enrollee's deductible and/or copayment) shall be refunded.

K. Utilization Review Requirements

Utilization review functions are performed by carriers unless specifically assigned by the Corporation to a Utilization Review Organization. These review functions may include, but are not limited to, predetermination and concurrent, retrospective and focused utilization reviews. In some instances, special review processes will be developed and implemented, as necessary and practicable, to address specific utilization concerns.

The utilization review function assesses the medical necessity and medical appropriateness of services for coverage consideration. The carrier or Utilization Review Organization's determinations shall be given full force and effect unless determined by the Plan Administrator to be contrary to the Program provisions or arbitrary and capricious.

1. Predetermination is the process by which the medical necessity for a given health care service, appropriateness of the service, or the proposed setting for the services is reviewed, and the proposed treatment plan is either approved or disapproved by a carrier or Utilization Review Organization before performance of such service. The review is performed to examine pertinent medical documentation of the need, appropriateness and setting for such service. Predetermination is not a guarantee of benefit payment. To be covered, the service must meet all terms and conditions of the Program.

   (a) For enrollees in the Basic Medical Plan and Enhanced Medical Plan, the services listed below shall be reported by the enrollee (or by the provider on his or her behalf) to the Utilization Review Organization or carrier, as appropriate, for predetermination:

      (1) Hospital admissions except maternity and emergency (Emergency admissions are to be reported to and reviewed by the Utilization Review Organization within 48 hours of inpatient admission.);

      The predetermination of inpatient care includes the designation of appropriate lengths of stay based on diagnosis, patient characteristics, and/or appropriate practice patterns;

      (2) Surgical procedures, regardless of place of service (Emergency outpatient surgical procedures are to be reported to and reviewed by the Utilization Review Organization within 48 hours of outpatient surgery.);

      (3) Home health care services; and

      (4) Skilled nursing facility admissions.

      Enrollees in the Comprehensive Health Savings Plan and those receiving out-of-network services through the Point of Service Plan will be required to report the services in (1) and may be required by the carrier to report some or all of the services in (2), (3), and (4) for predetermination. Under the Point of Service Plan, network providers are

responsible for obtaining any necessary pre-determinations.

(b) An appeal procedure will be available through the carrier or the Utilization Review Organization for medical review of disputed decisions prior to receipt of services. Decisions resulting from such an appeal procedure may be further appealed as set forth in Article I, Section 6.

(c) If services are determined to be not medically necessary, they are not covered under the Program and no benefits are payable.

(d) Benefits for covered services which require predetermination will be reduced by the lesser of $200 or the reasonable and customary charges prior to the application of deductible and copayment amounts, when necessary predetermination requirements are not met or the services are determined to be not medically appropriate. Any such liability incurred by an enrollee is in addition to the deductible and copayment amounts (which shall be determined after applying this provision) and will not be applied to an enrollee's out-of-pocket expense for purposes of applying annual maximums. This provision is not applicable to the POS Plan when services are received in-network upon referral from the primary care physician, but is applicable if the services are deemed to be out of the POS network.

(e) Benefit reductions referred to in subsection (d) above shall not be applicable to an individual enrollee who has incurred three such reductions in a calendar year.

(f) Primary and secondary enrollees who have Medicare or another group health care plan as their primary coverage are not subject to the predetermination and review procedures set forth above.

2. Concurrent Utilization Review is the process by which the necessity, appropriateness and setting of a given health care service are reviewed while the patient is receiving inpatient care.

3. Retrospective Utilization Review is the process by which the necessity, appropriateness and setting of

a given health care service are reviewed following the performance of the service. When retrospective review results in a determination that the admission or services were not medically necessary, recovery of any benefits paid for such admission or service will be made from the provider, subject to the limitations of the carrier's provider contracts. When the retrospective review results in a determination that the admission or services were not medically appropriate, a benefit reduction, as set forth in 1.(d) of this subsection, will be applied.

4. Focused Utilization Review is the process by which certain providers (professionals and facilities), procedures and/or diagnoses are reviewed to audit the necessity of a given health care service, appropriateness of the service, the setting of the service, the quality of care rendered, and the financial accuracy of claims submitted for reimbursement related to such services.

III. Description of Coverages

A. Hospital Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a hospital only if the following conditions have been met:

a. The admission and length of stay have predetermination approval from the Utilization Review Organization or carrier, as appropriate, for non-emergency, non-maternity admissions of enrollees in the Standard Medical Plan, Standard Plus Medical Plan, Point of Service Plan; Basic Medical Plan and Enhanced Medical Plan options, as set forth in Appendix A, II.K (emergency admissions must be reported to the carrier within 48 hours), or

b. Services are received on or after the enrollee's effective date of coverage under the Program.

c. For inpatient hospital services, the enrollee is admitted in accordance with the Program provisions, as administered by the carrier, and the hospital's rules and regulations governing admission as a bed patient, and is

under the constant care and treatment of a physician during the period of admission.

d. For inpatient hospital services, the enrollee has benefit days available under the hospital benefit period as set forth in Section II.B. above.

2. Inpatient Hospital Coverage

Upon admission to a participating hospital, or to any hospital for carriers without participating arrangements, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case, approved by the Utilization Review Organization or carrier, as appropriate, and provided and billed by the hospital:

a. Semiprivate room, general nursing services, meals, and special diets. Private room coverage will be provided only when such accommodations are medically necessary as set forth in an administration manual published by the Control Plan;

b. Use of operating rooms, other surgical treatment rooms, and delivery rooms;

c. Anesthesia services, anesthesia supplies, gases, and use of equipment;

d. Laboratory and pathology examinations which are under the direction of a pathologist employed by the hospital;

e. Chemotherapy (chemotherapeutics, antineoplastic agents and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is research, investigational or experimental in nature (See also Appendix A.III.L. regarding Centers of Excellence for non-routine cancer care);

f. Physical, speech, and functional occupational therapy (see App. A, III.C.);

g. Oxygen and other gas therapy;

h. Drugs, biologicals, and solutions used while the enrollee is in the hospital;

i. Gauze, cotton, fabrics, solutions, plaster, splints, and other materials used in dressings and casts;

j. Radioactive isotope studies and use of radium when the radium is owned or rented by the hospital;

k. Maternity care and routine nursery care of the newborn during the hospital stay of the mother for maternity care, when the mother is an enrollee. Coverage will comply with the Newborns and Mothers Health Protection Act of 1996;

l. Hospital service in a special care unit;

m. Blood services, including transfusions of whole blood and packed red blood cells (if not replaced), blood derivatives, blood plasma, supplies and their administration. Body component preservation and storage for future use are not covered expenses;

n. Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The determination of the carrier as to whether or not a hospital is a qualified hospital for providing hemodialysis shall be given full force and effect unless it is determined by the Plan Administrator to have been contrary to the Program provisions or arbitrary and capricious;

o. Durable medical equipment (see App. A, III.I.);

p. Prosthetic and orthotic appliances (see App. A, III.I.);

q. Hospital services for mastectomy or sterilization of male or female enrollees, regardless of medical necessity;

r. Hospital services for covered plastic and reconstructive surgery (see App. A, III.E.3.a.(1));

s. Hospital services for abortions regardless of the medical necessity for the abortion;

t. Pulmonary function evaluation;

u. Skin bank, bone bank and other tissue storage bank costs;

v. Inhalation therapy; and

w. Human organ and tissue transplants. For medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient, hospital services (including evaluation tests to establish compatibility and suitability of potential and actual donors when the tests cannot be done safely and effectively on an outpatient basis) are covered as follows:

(1) When the transplant recipient and the donor are both enrollees, benefits are provided for both;

(2) When the transplant recipient is an enrollee, but the living donor is not, benefits are provided for the transplant recipient and, to the extent they are not available under any other health care coverage, for the donor;

(3) When the living donor is an enrollee and the transplant recipient is not, benefits are provided only for the donor;

(4) When the transplant recipient is an enrollee, expenses incurred in the evaluation and procurement of cadaver organs and tissues are benefits when billed by the hospital. All such expenses will be charged to the enrollee's coverage to the extent that they are not covered by any other health care coverage of the donor or potential donor;

(5) For purposes of this subsection w. and of App. A, III.E.3.a.(3), "medically recognized" human organ or tissue transplants include allogeneic bone marrow for only specified diagnoses, autologous bone marrow for only specified diagnoses, cornea, heart, heart/lung, kidney, liver, lung, pancreas and skin. The limitations with respect to bone

marrow transplants are contained in Section IV.Z. of this Appendix. See also Appendix A,III.L. regarding Centers of Excellence for human organ transplants.

3. Outpatient Hospital Coverage

a. When an enrollee receives outpatient hospital services in a participating hospital, or any hospital for carriers without participating arrangements, which have been ordered by the attending physician and approved by the carrier (or Utilization Review Organization for services that require predetermination), the enrollee is entitled to the same coverages available on an inpatient basis, except that:

(1) Drugs, biologicals, and solutions are covered only to the extent they are used in the hospital and administered in connection with the use of operating or surgical treatment rooms, anesthesia, laboratory examinations, other outpatient hospital services, or, as of October 1, 1999, IV infusion therapy services.

(2) Physical, speech and functional occupational therapy also may be covered (see App. A, III.C.).

(3) Chemotherapy (chemotherapeutics, antineoplastic agents and necessary ancillary drugs and their administration) is covered for the treatment of malignant diseases except when the treatment is research, investigational or experimental in nature.

Chemotherapy is covered for the following routes of administration: parenteral, continuous or intermittent infusion, perfusion, and intracavitary. Coverage is not available for the oral administration of chemotherapy.

(4) Coverage does not include treatment of chronic conditions which require repeated visits to the hospital, except for hemodialysis and, as of October 1, 1999, IV infusion therapy services.

(5) Services in the emergency room of a hospital are covered for the initial

examination and treatment of conditions resulting from accidental injury or medical emergencies. A medical emergency will be considered to exist only if medical treatment is secured within 72 hours after the onset of the condition. Follow-up care is not covered, with the exception of follow-up care for rabies exposure.

If an emergency room patient is placed under observation care, hospital services are covered when such services are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the hospital. Coverage for such services is generally limited to 24 hours, unless the medical necessity of additional time is documented in the medical records and approved by the carrier.

(6) Hyperbaric oxygenation is covered when medically necessary for treatment of disease or injury. Coverage is not available for treatment of chronic conditions.

(7) Skin bank, bone bank and other tissue storage bank services are not covered.

b. Hemodialysis (use of kidney machine) or peritoneal dialysis for the treatment of a chronic, irreversible kidney disease is covered in an enrollee's home when services are provided and billed by a hospital which has a hemodialysis program approved by the carrier.

(1) Benefits will not be payable unless the following conditions are met:

(a) treatment must be arranged through the physician attending the enrollee and the physician director or a committee of staff physicians of the training program, and

(b) the owner of the enrollee's residence must give written permission to the hospital for installation of the equipment prior to its installation.

(2) The following are covered expenses under this subsection:

(a) purchase, lease, or rental (as determined by the carrier to be appropriate) of a hemodialysis machine placed in the enrollee's home;

(b) installation and maintenance or repair of a hemodialysis machine placed in the enrollee's home;

(c) hospital expenses for training the enrollee and any individual who will be assisting the enrollee in the home setting in operating the hemodialysis machine;

(d) laboratory tests related to the dialysis procedure;

(e) consumable and expendable supplies required during the dialysis procedure, such as dialysis membrane, solution, tubing, and drugs; and

(f) removal of the dialysis equipment from the enrollee's home when the enrollee no longer needs the equipment.

(3) The following are not covered expenses under this subsection:

(a) services not provided and billed by a hospital with a hemodialysis program approved by the carrier;

(b) reimbursement to individuals trained and assisting in the dialysis procedure;

(c) electricity or water used in operating the dialyzer;

(d) installation of electric power, a water supply, or a sanitary waste disposal system in conjunction with installing the dialysis equipment;

(e) physician's services, except to the extent the physician is reimbursed by the hospital for administration and overall supervision of the program;

(f) transfer of the dialyzer to another location in the enrollee's residence;

(g) services performed prior to the effective date of the home hemodialysis program; and

(h) services provided by an agency or organization providing "back-up" assistance in home hemodialysis, including the services of hospital personnel sent to the enrollee's home, or of other persons under contract with the hospital.

4. Limitations and Exclusions

a. Coverage for hospital admissions and services is only for the period which is medically necessary for the proper care and treatment of the enrollee, subject to the maximum benefit period and other applicable Program provisions. As a condition of continued hospital coverage, the carrier or Utilization Review Organization may require written verification by the physician in charge of the case of the need for services. For purposes of this subsection and subsection 4.b. below, the carrier or Utilization Review Organization shall review the severity of the patient's illness and the nature and intensity of services required/provided and, based upon such review, shall have discretionary authority to interpret, apply and construe these provisions of the Program. The carrier's or Utilization Review Organization's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage does not include hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care.

c. Coverage does not include hospital services consisting principally of dental treatment or extraction of teeth, as provided in Appendix A, III. E.3.a.(2).

d. Coverage does not include inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication, or environmental control.

e. Coverage for hospital services does not include services of physicians, oral surgeons, or services covered elsewhere in this Appendix, such as x-ray examination or therapy, electrocardiography, cobalt, or ultrasound studies.

f. The enrollee must give notice of coverage to any hospital at the time of admission. If notice is not given at that time, the enrollee may be liable for a portion of charges incurred.

g. If an enrollee cannot obtain admission to participating or nonparticipating hospitals, the carrier may pay the enrollee an amount not to exceed $65 for the expense of nursing and other services and supplies, restricted to the equivalent of hospital care made necessary by the illness or injury. The payment shall be full satisfaction of all obligations of the carrier and the participating hospitals to furnish hospital service for the disability for which admission was sought; provided, however, that if the admission is for the care of contagious or epidemic disease, or injury due to war, declared or undeclared, the Corporation, the carriers and the participating hospitals are under no obligation or liability under this Program.

h. Hospital coverage does not include facility charges for care received in an urgent care center.

i. Hospital coverage does not include facility charges for care received in a freestanding

ambulatory surgery center, unless such center meets Program standards and is approved by the carrier.

j. Hospital coverage does not include facility charges related to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision), sterilization reversals or non-covered plastic, cosmetic, or reconstructive surgery.

k. Hospital coverage does not include positron emission tomography (PET) scanning services.

l. Coverage for hospital services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

B. Skilled Nursing Facility Coverage

1. Conditions of Benefit Payments

All skilled nursing admissions must be predetermined by the Utilization Organization or carrier, as appropriate.

An enrollee is eligible for benefits for covered expenses incurred in a skilled nursing facility only if the following conditions have been met:

a. The services are received on or after the enrollee's effective date of coverage under this Program.

b. The admission has been approved by the Utilization Review Organization or carrier, as appropriate, and the enrollee is admitted to the skilled nursing facility by the order of a physician who certifies that the enrollee requires the type of care available at the facility.

c. The enrollee has benefit days available under the skilled nursing facility benefit period (see App. A, II.B.).

d. The care received by the enrollee consists of definitive medical, nursing, or other paramedical care.

2. Coverages

a. Upon admission to a skilled nursing facility approved by the carrier, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case and when provided and billed by the facility:

(1) Semiprivate room, general nursing service, meals, and special diets;

(2) Use of special treatment rooms;

(3) Routine laboratory examinations;

(4) Physical, speech, or functional occupational therapy when medically necessary for the treatment of the enrollee (see App. A, III.C.);

(5) Oxygen and other gas therapy;

(6) Drugs, biologicals, and solutions used while the enrollee is in the facility;

(7) Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts; and

(8) Durable medical equipment (see App. A, III.I.).

b. Medical care in skilled nursing facilities: Coverage is provided for medical care approved by the Utilization Review Organization or carrier, as appropriate, in a skilled nursing facility by the physician in charge of the case. Care is subject to the 730-day benefit period maximum. Medical care in a skilled nursing facility for the treatment of tuberculosis or substance abuse is not covered.

3. Limitations and Exclusions

a. Skilled nursing facility admissions and services are covered only when the services are medically necessary. As a condition of continued skilled nursing facility coverage, the Utilization Review Organization or carrier, as appropriate, may require written verification by the physician in charge of the case of the need for services. For the purposes of this subsection and of subsection

3.b., below, the Utilization Review Organization or carrier shall review the severity of the patient's illness and the nature and intensity of the services required/provided and, based upon such review, shall have discretionary authority to interpret, apply and construe these provisions of the Program. The exercise of this authority by the Utilization Review Organization or the carrier shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage is not provided for care which is principally custodial or domiciliary or for care of tuberculosis.

c. Notwithstanding a. and b. above, for the period of time the Program is secondary to the payment of Medicare benefits for skilled nursing facility services, Medicare's determination of coverage will be deemed to satisfy Program criteria as to medical necessity and maintenance, domiciliary and custodial care. However, if the carrier or Control Plan become aware of the admission during such period of time, the Control Plan, or another designated party, shall review the admission and advise the enrollee as to ongoing coverage before the exhaustion of Medicare benefits.

d. Coverage for skilled nursing facility services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

C. Physical, Functional Occupational and Speech Therapy and Cardiac Rehabilitation Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered physical, functional occupational and speech therapy and cardiac rehabilitation expenses only if the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the carrier, prescribed by the physician in charge of the case, and provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational or speech therapist for the specific therapy prescribed;

c. Services are provided and billed by a physician (other than a limited-practice physician) or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility, or independent therapist approved by the carrier; and

d. Benefits are available during the benefit period for covered hospital or skilled nursing facility inpatient care.

2. Coverages

Services are covered as follows:

a. Physical Therapy and Functional Occupational Therapy

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee is entitled to receive physical and functional occupational therapy to the extent medically necessary for the treatment of the condition for which the enrollee is admitted. If rehabilitation care is prescribed and approved, the rehabilitation program is expected to include, at a minimum:

(a) Medical care and supervision by a physician with specialized training and/or experience in rehabilitation, with 24-hour per day physician availability in addition to physician evaluation of the patient at least three times per week;

(b) The active involvement in the patient's care of a nurse with specialized training and/or experience in rehabilitation nursing (including 24-hour immediate, on the premises, availability of a registered nurse with specialized

training and/or experience in rehabilitation nursing);

(c) Social work services;

(d) Physical therapy services;

(e) Plus one or more of the following:

(i) occupational therapy;

(ii) speech therapy;

(iii) psychological services;

(iv) prosthetic and/or orthotic fabrication and fitting.

(2) Enrollees are entitled to receive physical therapy and functional occupational therapy provided through an approved home health care agency. When special equipment not easily made available in the home is required, an enrollee is entitled to coverage for such services in a hospital or freestanding outpatient physical therapy facility participating with the home health care agency when related to the condition for which the enrollee was admitted to the home health care program.

(3) Physical therapy and/or functional occupational therapy are covered on an outpatient basis when performed to restore or improve musculoskeletal function.

b. Speech Therapy

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee is entitled to receive speech therapy on the same basis as described in subsection 2.a.(1) above.

(2) Enrollees are entitled to receive speech therapy provided through an approved home health care agency.

(3) Restorative speech therapy (speech pathology) is covered on an outpatient basis when related to the treatment of an

organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness. Speech therapy is not covered for long-standing, chronic conditions, or inherited speech abnormalities except as set forth in subsection b.(4) below.

(4) Speech therapy for congenital and severe developmental speech disorders is covered when not available through other public agencies (e.g., state or school).

(a) In order to be covered, the enrollee must be diagnosed as having a severe communicative deficit as defined by Program standards.

(b) Speech therapy is not covered for:

(i) educational learning disabilities (e.g., dyslexia);

(ii) deviant swallow or tongue thrust;

(iii) mild developmental speech or language disorders;

(iv) congenital deafness;

(v) elimination of a lisp, or similar defect in articulation; or

(vi) improving speech that is not fully developed.

(c) Initial and interim patient assessment to determine severity of condition, potential for improvement, progress and/or readiness for discharge from treatment is considered part of the overall treatment program and is a covered service when accompanied by treatment.

(d) Steady improvement as a consequence of treatment must be documented in periodic interim reports. Such documentation must be available to the carrier upon request.

c. Cardiac Rehabilitation

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee may receive cardiac rehabilitation on the same basis as therapy described in subsection 2.a.(1) above.

(2) Enrollees may receive cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician. The payment of benefits for cardiac rehabilitation on an outpatient basis is limited to services provided during the six-month period immediately following acute myocardial infarction, initial diagnosis of angina pectoris, or certain heart surgeries.

3. Limitations and Exclusions

a. Covered expenses will not include and benefits are not payable for:

(1) physical, functional occupational and/or speech therapy services if:

(a) such services are provided without expectation that the condition will improve in a reasonable and generally predictable period of time,

(b) improvement does not occur, as documented in the patient's record on a periodic basis, or

(c) progress is no longer being made or the previous level of function has been restored;

(2) physical therapy and/or functional occupational therapy provided solely to maintain musculoskeletal function;

(3) occupational therapy which is not functional in nature;

(4) inpatient admissions which are principally for physical, functional

occupational and/or speech therapy or for cardiac rehabilitation;

(5) manipulation, adjustment or massage of the musculoskeletal system;

(6) vision therapy or training;

(7) cognitive rehabilitation which includes, but is not limited to, vocational rehabilitation, recreational therapy, learning exercises for retraining in routine activities of life or aspects of cognitive functioning such as concentration, organizational skills, information processing, memory, thinking, and problem solving;

(8) day, night or residential rehabilitation programs;

(9) services which could be performed by an untrained, unlicensed person, by the enrollee, or by a member of the enrollee's family;

(10) isokinetic testing or treatment;

(11) debridement and cleansing with whirlpool for first or second degree burns;

(12) physical and/or functional occupational therapy for first and second degree burns.

b. Coverage for physical, functional occupational and speech therapy and cardiac rehabilitation is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

D. Home Health Care Coverage

1. Conditions of Benefit Payments

Home health care services are subject to predetermination by the Utilization Review Organization or carrier, as appropriate. An enrollee is eligible for benefits for covered expenses incurred for home health care services only if the following conditions have been met:

a. The home health care services are received on or after the enrollee's effective date of coverage in this Program;

b. The enrollee is referred to and accepted by a home health care agency that meets Program standards and is approved by the local carrier;

c. The services received are approved by the Utilization Review Organization or carrier, as appropriate, prescribed by the physician in charge of the case and provided and billed by an approved provider;

d. The physician in charge of the case certifies to the carrier that skilled home health care services are medically necessary for the care of the enrollee; and

e. The enrollee is essentially homebound for medical reasons and physically unable to routinely obtain the needed medical services on an outpatient basis without special assistance. The homebound requirement does not apply to covered IV infusion therapy services.

2. Coverages

a. The following services are covered when provided on a part-time or intermittent basis during a home health care visit and billed by a home health care agency approved by the carrier:

(1) General nursing services;

(2) Physical therapy and speech therapy (may be provided and billed by a hospital outpatient department or a carrier-approved physical therapy provider under limited circumstances - see App. A, III.C.2.);

(3) Social service guidance, dietary guidance, and functional occupational therapy; and

(4) Services by a home health aide employed by an approved home health care agency. To be eligible for home health aide service, the enrollee must be receiving

one of the services in (1) or (2) above, and it must be determined by the home health care agency and the Utilization Review Organization or carrier, as appropriate, that the enrollee could not be treated under this subsection without the home health aide service.

b. For the purposes of this subsection III.D.:

(1) A home health care visit consists of a visit

(a) to the enrollee's home by any member of the home health care team for the purpose of providing necessary professional service;

(b) to the enrollee's home by a home health aide for the purpose of providing covered home health aide services as described in subsection 2.a.(4) above; or

(c) by the enrollee to a hospital or skilled nursing facility or approved physical therapy provider as an outpatient for speech evaluation or physical therapy when required equipment is not easily available for home use;

(2) "part-time care" means:

(a) up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or

(b) up to 35 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day, subject to individual review and approval by the Utilization Review Organization or carrier, as appropriate, based on diagnosis, prognosis and documented improvement in the patient's condition; and

(3) "intermittent care" means:

(a) part-time care as described in subsections (2)(a) and (b) above, which is provided on less than a daily basis; or

(b) up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, for a temporary period not to exceed one month, subject to review and approval by the Utilization Review Organization or carrier, as appropriate, based on diagnosis, prognosis and documented improvement in the patient's condition.

c. The following services are covered when provided and billed by an approved provider:

(1) Laboratory tests;

(2) Drugs, biologicals, and solutions; and

(3) Medical supplies which are essential in order to effectively administer in the home the medical regimen ordered by the physician. Supplies include items such as bandages, dressings, splints, hypodermic needles, catheters, colostomy appliances, and oxygen. When covered home health care services are being provided, medical supplies used in the home for the patient's care will be covered under this section, even if used during a portion of the day or week when nursing services are not covered.

d. IV infusion therapy services in the home are covered under home health care coverage. The following provision will apply to such services:

(1) The "homebound" requirement will be waived with respect to home infusion therapy patients;

(2) Related nursing services will be included;

(3) Applicable prescription drugs will be included;

(4) All services directly related to infusion therapy, including DME, parenteral and enteral methods of hyperalimentation, chemotherapy, and supplies, will be covered under Home Health Care coverage;

(5) The provision that limits home health care benefits to three visits for each remaining inpatient hospital day will be waived; and

(6) Home IV infusion therapy services will be covered only when delivered by a provider that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. Limitations and Exclusions

a. Coverage for home health care services is available only when the services are medically necessary. As a condition of continued home health care coverage, the Utilization Review Organization or carrier, as appropriate, may require written verification by the physician in charge of the case of the need for services. The Utilization Review Organization or carrier, as appropriate, shall have discretionary authority to interpret, apply and construe this provision of the Program. The Utilization Review Organization's or carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage under this subsection does not include supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances which may be covered under the durable medical equipment and prosthetic or orthotic appliance provisions (such as hospital beds, oxygen tents, walkers, wheelchairs, or orthotics).

c. Coverage under this subsection does not include physician services, private duty nursing services or housekeeping services.

d. Coverage under this subsection does not include skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels.

e. Coverage under this subsection does not include home uterine monitoring.

f. Coverage under this subsection does not include charges for travel time.

g. The maximum amount of reimbursable expense for home health care services under this subsection is limited to the amount which would be reimbursable for similar care rendered in a skilled nursing facility.

h. Coverage for physical, functional occupational, and speech therapy provided in accordance with subsection D.2.a. (2) and (3) above are subject to the limitations and exclusions in Appendix A, III.C.3.

i. Coverage for home health care services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

E. Surgical and Medical Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for expenses incurred for surgical and medical covered services only when the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the carrier, when necessary (or the Utilization Review Organization for services that require predetermination); and

c. Services are received prior to the termination date of the enrollee's coverage, except that services received during hospital admissions which commence prior to such termination date will be covered subject to other provisions of this Program.

2. Payment of Services

a. The carrier(s) will make payment according to a fee schedule, capitation schedule, or reasonable and customary charges.

b. A carrier will make the benefit payments directly to the provider for services performed or materials furnished by such provider, or directly to the enrollee if appropriate.

c. The carriers shall have discretionary authority to interpret, apply and construe these reimbursement provisions of the Program. A carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious. The carrier will defend its determination of the fee, capitation rate or reasonable and customary charge if a provider claims an amount in excess of the carrier's determination from the enrollee and there is no payment or prior written agreement between the patient and the provider regarding the amount of the provider's charges.

d. Certain hospital-based physician services billed by a hospital will be paid directly to the hospital by a carrier according to the carrier's agreement with the hospital.

3. Coverages

Except as otherwise indicated, the following services are covered:

a. Surgery: Subject to the limitations listed below, surgical services, consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of diseases, injuries, fractures, or dislocations, are covered when performed by the physician in charge of the case.

Surgical services require predetermination as described in Appendix A.II.K.

Surgical services include usual, necessary, and related preoperative and postoperative care performed in or out of the hospital.

(1) Plastic and reconstructive surgery is limited to the correction of congenital anomalies and conditions resulting from accidental injuries or traumatic scars, to the correction of deformities resulting from cancer surgery or following medically necessary mastectomies (including medically necessary mastectomies resulting from cancer or fibrocystic disease), and to blepharoplasties when there is visual impairment.

Notwithstanding the above, in compliance with the Women's Health and Cancer Rights Act of 1998, in the case of an enrollee who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, coverage includes: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

(2) Dental surgery is limited to multiple extractions, removal of one or more unerupted teeth, alveoloplasty, or gingivectomy, and is covered only when performed in a facility setting (i.e., hospital inpatient or outpatient or Freestanding Ambulatory Surgical Center), when a concurrent hazardous medical condition exists and when Program Standards are met. Surgical procedures to excise tumors or cysts of the oral cavity, to correct fractures of facial or jawbones, dislocations and disorders of joints, or to correct accidental injury are not considered dental surgery and are considered in accordance with the general surgery provisions above.

(3) For medically recognized human organ or tissue transplants [see App. A, III.A.2.w.(5)] from a living or cadaver donor to a transplant recipient which requires surgical removal of a donated part, benefits for services as listed and

limited in this subsection (including laboratory services for evaluation tests to establish a potential donor's compatibility and suitability) will be covered in the same manner as under Section III.A.2.w.

Payments will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants and charitable organizations.

Centers of Excellence Facilities, as describe in Appendix A.III.L., may be utilized, where appropriate, for covered human organ or tissue transplants.

(4) Surgical procedures for mastectomy or for sterilization of male and female enrollees irrespective of medical necessity are covered. Sterilization reversals are not covered.

(5) Laser surgery is covered if the alternative cutting procedure is covered. The maximum benefit payable for laser surgery is the reasonable and customary charge for the alternative cutting procedure.

b. Hemodialysis: Services are covered only when performed by a physician in a facility meeting Program standards and approved by the local carrier or in the enrollee's home.

c. Anesthesia: Services for the administration of anesthetics are covered, when provided by a physician, other than the operating physician, and when required by, and performed in conjunction with, another covered service.

(1) Anesthesia services provided by a physician for covered services are payable in all settings that are appropriate for the covered surgical or diagnostic service being performed, including inpatient hospital, outpatient hospital, freestanding ambulatory surgical center, and physician's office.

(2) Anesthesia services include the administration of anesthesia by a Certified Registered Nurse Anesthetist (CRNA) or an Anesthesia Assistant (AA) working under the medical direction of an anesthesiologist who is available for immediate attendance. CRNA services are also covered if performed under the general supervision of a physician who is not an anesthesiologist and who is available for immediate attendance. .

(3) CRNAs must attain specialty certification from the Council on Certification of Nurse Anesthetists and be state licensed. AAs must be graduates of an educational program accredited by the Commission on Accreditation of Allied Health Education Programs, be certified by the National Commission for the Certification of Anesthesiologists Assistants and the National Board of Medical Examiners, and work under the supervision of a licensed MD or DO who is responsible for overall provision of anesthesia to the patient. Anesthesia services performed by CRNAs or AAs are payable in the inpatient hospital, outpatient hospital or free-standing ambulatory surgical center settings.

(4) Administration of local anesthetics is not covered. Anesthesia services, supplies, gases and use of equipement provided by a hospital are covered only under Section III.A.2.c.

d. Technical surgical assistance: Services by a physician or a physician assistant who actively assists the operating physician are covered when medically necessary and when related to covered surgical or maternity services. In order for the services of the assistant surgical physician or a physician assistant to be covered, it must be certified that the services of interns, residents, or house officers were not available at the time. In order for technical surgical assistance performed by a physician assistant to be covered, the physician assistant must be legally qualified and registered, certified and/or licensed, as applicable, to perform

these health care services. The physician assistant must meet Program standards and be approved by the carrier. Reimbursement for technical surgical assistance services performed by a physician assistant will be made to the employer of the physician assistant.

e. Maternity care: Obstetrical services of a physician or a certified nurse mid-wife, including usual prenatal and postnatal care, are covered. For each pregnancy, coverage is also provided for routine prenatal laboratory examinations which are performed in connection with normal maternity care. Covered obstetrical services provided by a certified nurse-midwife are limited to basic antepartum care, normal vaginal deliveries, and postpartum care. For a given uncomplicated pregnancy, reimbursement for such care would be to the physician or the certified nurse-midwife, but not both. Certified nurse-midwives are reimbursed only for deliveries occurring in the inpatient setting or in a birthing center that is hospital affiliated, state licensed and accredited and approved by the carrier. The certified nurse-midwife must be legally qualified and registered, certified and/or licensed, as applicable, to perform these health care services. The nurse-midwife must meet Program standards and be approved by the carrier. Coverage includes:

(1) the examination of a newborn child by a physician other than the delivering physician, certified nurse mid-wife or the physician administering anesthesia during delivery; and

(2) obstetrical services of a physician for an abortion.

f. Consultations: When requested by the physician in charge of the case, coverage is provided for the assistance of a physician in the diagnosis or treatment of a condition which requires special skill or knowledge. This coverage does not include phone consultations or staff consultations required by a facility.

g. Chemotherapy: Coverage for chemotherapy is provided under App. A, III.A.2.e. for inpatient care and under App. A, III.A.3.a.(3)

for outpatient care. Chemotherapy administered in a physician's office is covered on the same basis as outpatient and excludes services which are research, investigational or experimental in nature. (See also Appendix A, III.L. regarding Centers of Excellence for non-routine cancer care.)

h. Extra-corporeal shock wave lithotripsy (ESWL): Coverage is provided for services rendered in a carrier-approved facility meeting Program standards.

i. Therapeutic radiology: Coverage is provided for treatment of conditions by x-ray, radium, radon, external radiation, or radioactive isotopes (e.g., cobalt), and includes the cost of materials provided which are not supplied by a hospital.

j. Diagnostic radiology: Coverage is provided if approved by the carrier as required, for diagnosis of any condition, disease, or injury by x-ray, ultrasound, isotope examination, computerized axial tomography (CAT), magnetic resonance imaging (MRI) and positive emission tomography (PET) scanning, mammography and other modalities. Coverage restictions include, but are not limited to the following:

(1) Computerized axial tomography is covered for diagnostic examinations of the head and body when ordered by a physician and performed on approved equipment in accordance with Program standards.

(2) Digital subtraction angiography is covered if performed on hospital based equipment.

(3) Magnetic resonance imaging (MRI) and positive emission tomography (PET) scanning coverage is provided in accordance with Program standards, which include diagnosis restrictions and the use of carrier-approved facilities.

(4) Positron emission tomography (PET) is a covered procedure when performed in accordance with Program standards for covered conditions and approved providers.

(5) The maximum benefit payable for digital mammography is the reasonable and customary charge for the alternative standard film mammogram.

k. Laboratory, pathology and other services: Coverage is provided if approved by the carrier for laboratory and pathological examinations for the diagnosis of conditions, diseases, or injuries or for performing covered well child care services and physical examinations. In addition to examinations of blood, tissue, and urine, diagnostic laboratory and pathology coverage includes laboratory procedures such as electrocardiograms, electroencephalograms, electromyograms, and basal metabolism tests.

(1) Routine laboratory services in connection with normal maternity care are covered according to the provisions of Section III.E.3.e.

(2) Hearing aid evaluation tests are covered only under Section III.H. of this Appendix.

(3) Audiometric examinations may be covered, but are subject to the exclusions of Appendix A, III.H.5.a., d., e., g., h., i., j., k., and l.

l. Physician medical visits: Coverage is provided for medical visits by a physician when rendered in the physician's office, the home, a hospital, or a skilled nursing facility for the examination, or diagnosis and treatment of any condition, disease or injury subject to the provisions below.

(1) Inpatient medical care is covered when provided by the physician in charge of the case. Services of a physician who is treating a condition unrelated to the reason for the admission may also be covered.

(2) Treatment rendered in or at a hospital is covered only when provided by a physician who is not an employee of the hospital.

(3) Well childcare is covered for enrollees six years of age or younger.

(4) Routine physical examinations are covered for enrollees over six years of age and are limited to one each calendar year.

(5) Physician medical visit coverage does not include services or separate charges for the following (although some of the items may be covered under other provisions of the Program):

(a) mental health or substance abuse treatment;

(b) prenatal and postnatal care;

(c) immunizations;

(d) routine eye examinations;

(e) insurance, employment and premarital examinations;

(f) manipulation, adjustment or massage of the musculoskeletal system;

(g) allergy testing, treatment or injections;

(h) weight control;

(i) acupuncture; or

(j) services provided by non-physician practitioners, e.g., Physician Assistants, Christian Science practitioners, etc.

m. Immunizations and injections: Coverage is provided for medically recognized immunizations and injections as approved by the carrier.

(1) Serum is covered only when it is not supplied by a health department or other public agency.

(2) Vitamin and iron injections are covered only when required and necessary for diagnosed illness.

(3) Injections for chelation therapy are not covered, unless they meet Program

standards as to diagnosis and the nature of the service(s) performed. Chelation therapy by means other than injection may be covered under other provisions of the Program.

(4) Allergy injections are not covered.

(5) Injections covered under another Section of this Appendix (e.g., chemotherapy) are not covered.

n. Foot care: Coverage is provided for treatment of injuries and/or infections of the feet. Routine foot care (e.g., cutting, paring, debridement and curettement of nails, corns, calluses and other hyperkeratotic or benign lesions and treatment of mycotic toe nails) is covered only for enrollees with a confirmed diagnosis of diabetes or peripheral vascular disease and is subject to Program standards regarding frequency.

o. Screening examinations: Coverage is provided in accordance with the provisions of subsections E.3.j. and k., above, for appropriate examinations and procedures prescribed by a physician and performed solely for early detection of a pathological condition in an otherwise asymptomatic individual. However, the deductible and copayment provisions otherwise applicable to services performed for enrollees of particular options, under Article II, Section 4 of the Program, do not apply to:

(1) laboratory and pathological services for one routine Papanicolau (PAP) smear per enrollee per calendar year to detect cancer of the female genital tract,

(2) one proctoscopic exam without biopsy performed within each three calendar year period after age 40 is attained, or

(3) one routine screening or diagnostic mammogram per calendar year for enrollees age 40 and older who meet Program standards.

(4) one screening or diagnostic prostate specific antigen (PSA) test per calendar

year for enrollees age 40 or older who meet Program standards.

(5) one routine screening or diagnostic sigmoidoscopy or barium enema X-ray every five calendar years or one colonoscopy every 10 calendar years for enrollees age 50 or over.

(6) one routine screening or diagnostic fecal occult blood test per calendar year for enrollees age 50 or over.

(7) One routine screening or diagnostice total serum cholesterol test every five calendar years for enrollees age 20 or over.

(8) When a covered diagnostic test requires injection of a drug, biological or solution in order to perform the test, the drug, biological or solution and the injection of it are covered, subject to carrier billing and reimbursement practices. For purposes of this subsection only, injections of thyrogen are covered in conjunction with covered thyroid scans.

p. Contraceptive services: Medical and surgical coverage for contraceptive services is limited to injections of contraceptive medication (professional fees and medication for injection), implantable contraceptives and their insertion or removal, intrauterine devices and their insertion or removal, cervical caps and their fitting, and the fitting of diaphragms. Coverage under this Section does not include over-the-counter contraceptive devices or diaphragms. (See Appendix A. III.G. for prescription drug coverage provisions regarding oral contraceptives, injectable contraceptive medication, contraceptive patches and diaphragms.)

4. Limitations and Exclusions

a. Dental services, including extraction of teeth, except as provided for in Section III.E.3.a.(2), are not covered under this subsection.

b. Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, insurance, pre-employment or premarital examinations are not covered.

c. Services of stand-by physicians are not covered.

d. Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision) are not covered.

e. Invasive electromagnetic bone growth stimulation is not covered.

f. Growth factor treatment for wound care (e.g., Procuren) is not covered.

g. Thermography services are not covered.

h. Coverage for surgical and medical services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

F. Ambulance Service Coverage

1. Conditions of Benefit Payments

Ambulance services are covered if the following conditions and requirements are met:

a. Ambulance services must be medically necessary. Ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health.

b. The ambulance operation providing the service must be licensed and meet Program standards.

c. A physician must prescribe the services which necessitate the use of ambulance transportation.

2. Coverages

The reasonable and customary charges for the following services are covered when furnished and billed by an eligible provider (as determined by the carrier):

a. Charges for basic life support services - a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as basic life support services. Basic life support consists of services which provide for the initial stabilization and transport of a patient.

b. Charges for advanced life support services -- a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as advanced life support services. Advanced life support is acute emergency treatment procedures with physician involvement.

c. Mileage charges -- a charge per mile for distances traveled while the enrollee occupies the ambulance vehicle.

d. Waiting time -- a charge for waiting time involved in round-trip transport of an enrollee from a hospital to another treatment site and return to the same hospital.

When services are received from an ambulance operation approved by the carrier, the carrier will reimburse the provider for the reasonable and customary charges as determined by the carrier. An approved provider must agree to accept, as payment in full, the carrier's determination of the amount payable for covered ambulance services.

When services are received from an otherwise eligible, but non-approved provider, the carrier will pay the enrollee the reasonable and customary charge as determined by the carrier.

3. Limitations and Exclusions

a. The following services are not covered as separate charges; such charges are included in the benefit payment for the standard charge per trip:

(1) Use of specific equipment or devices;

(2) Gases, fluids, medications, dressings, or other supplies;

(3) First aid, splinting, or any emergency medical services or personal service procedures; and

(4) Vehicle operators, attendants, or other personnel.

The charges for these services, while not covered as separate charges, are covered as a component of the charge for the basic or advanced life support services.

b. Coverage is limited to the reasonable and customary charges for transporting the patient to the nearest medical facility qualified to treat the enrollee.

c. Services of air and boat ambulance are subject to individual review.

(1) If the patient is transported to a facility other than the nearest medical facility qualified to treat the enrollee, benefits are allowed in an amount equal to that for transportation to the nearest facility.

(2) If transport by air or boat is not medically necessary, benefits are allowed in an amount equal to that for ground transportation for the same transfer.

d. Coverage does not include the following:

(1) Transportation in a vehicle not qualified as an ambulance;

(2) Transportation for enrollee, family or physician convenience;

(3) Services rendered by fire departments, rescue squads or others whose fee is in the form of a voluntary donation;

(4) Transfers not medically necessary;

(5) Fees, billed by physicians or other independent health care providers, for professional services rendered to enrollees transported by ambulance;

(6) Fees for services when the enrollee is not actually transported while under care; and

(7) Services which are payable through an existing arrangement for transfer of patients, where no additional charge is usually made, whether or not such services were immediately available.

e. Coverage for ambulance services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

G. Prescription Drug Coverage

1. Definitions

For the purposes of this subsection:

a. "brand name drug" means a drug which is covered by a patent and for which an equivalent version can not be manufactured or marketed (single source) or a drug which is no longer covered by a patent and for which chemically equivalent versions can be manufactured and marketed (multi-source). "Brand name drugs" may be either "preferred" or "non-preferred" as determined by the carrier.

b. "copayment" means an amount to be paid by the enrollee for each separate prescription order or refill of a covered drug.

c. "covered drug or supplies or diaphragm" means insulin or any prescription legend drug (except as excluded under subsection G.5. below) that is dispensed according to a prescription order, provided that:

(1) the drug or supply is medically necessary for the treatment of an illness or injury or, effective January 1, 2000, is a contraceptive medication or diaphragm;

(2) the cost of the drug is not included or includable in the cost of other services or supplies provided to the enrollee;

(3) the drug is customarily dispensed according to a prescription order; and

(4) the drug is not entirely consumed at the time and place of the prescription order.

"supplies" refers to syringes and needles dispensed with self-administered insulin or covered self-administered antineoplastic or chemotherapeutic drugs or agents under the provisions of this subsection.

"diaphragm" refers to a self-administered contraceptive device.

d. "generic drug" means a drug that is chemically equivalent to a multi-source brand name drug.

e. "nonparticipating provider" means a provider who has not entered into a contract with the carrier.

f. "participating provider" means a provider who has entered into a contract with a carrier to provide a covered drug to an enrollee, in accordance with the provisions of this Program and this subsection. Such contract shall provide for payment to the provider based on prescription charges. In the case of a preferred provider organization which provides prescription drug coverage under the Program, participating providers are the organization's panel pharmacies.

g. "pharmacist" means a person licensed to dispense prescription legend drugs under the laws of the state where such person practices.

h. "pharmacy" means a licensed establishment where prescription legend drugs are dispensed by a pharmacist.

i. "prescription charge" means a dispensing fee plus the lesser of the reasonable and customary amount paid by the provider for a covered drug (including insulin and disposable syringes and needles) or such amount as may be negotiated by the carrier with participating providers. The "dispensing fee" is an amount or amounts, including applicable sales tax, predetermined by the carrier to compensate participating providers for dispensing covered drugs.

For covered drugs obtained from a nonparticipating provider or from a provider

in an area where the carrier does not provide the coverage, the prescription charge means the reasonable and customary charge as determined by the carrier.

j. "prescription legend drug" means any medicinal substance which, under the Federal Food, Drug and Cosmetic Act, is required to be labeled "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only" and includes compounded medications containing at least one prescription legend drug.

k. "prescription order" means a written or oral request to a provider by a physician for a single prescription legend drug.

l. "provider" means a pharmacy or any other organization or person licensed to dispense prescription legend drugs.

2. Reimbursement

a. The copayment amount for each separate prescription order or refill of a covered drug shall be $5, or the prescription charge, whichever is less, for a generic drug and 25% of the prescription charge for a brand name drug, as defined in 1.a. of this subsection III.G., except that the copayment shall be:

(1) The prescription charge, if that amount is less than or equal to $15;

(2) Not less than $15, if the prescription charge exceeds that amount;

(3) Not more than $35; and

(4) $12 for generic and $40 for brand prescriptions dispensed through the Mail Order Prescription Drug program.

b. Except for the amounts indicated above, covered drugs or supplies obtained from a participating provider are covered subject to the Program provisions.

c. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of 75% of the reasonable and customary charge, as determined by the carrier after deduction of the

copayment, of covered drugs obtained on a non-emergency basis from a nonparticipating provider located within the area in which the carrier provides coverage.

d. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of 100% of the reasonable and customary charge, as determined by the carrier after deduction of the copayment, of covered drugs obtained from a provider located outside the area in which the carrier provides coverage or from an in-area nonparticipating provider in the case of an emergency (as determined by the carrier).

3. Coverage

a. Coverage includes up to a 34-day supply of a covered drug

b. Coverage includes an appropriate supply of disposable syringes and needles when prescribed and dispensed with a supply of self-administered insulin or a covered self-administered antineoplastic or chemotherapeutic agent.

c. Coverage includes up to a 90-day supply of covered drugs obtained through the Mail Order Prescription Drug program with a corresponding prescription or refill order. Diaphragms are not available through the mail order pharmacy.

4. Maximum Allowable Cost Programs

Maximum Allowable Cost (mandatory generic substitution) prescription drug programs or alternative generic substitution programs are applicable where in effect.

5. Prior Authorization Process

Upon the recommendation of the carrier and the approval of the Plan Administrator, certain prescription legend drugs will require prior authorization by the carrier to be covered under the Program. Prior Authorization is a process whereby the carrier determines before the prescription legend drug is dispensed that the drug is being prescribed appropriately according to FDA approvals and the manufacturer's recommendations.

Depending on the prescription, prior authorization may be required before the initial prescription is filled or it may be required after a certain quantity of the prescription legend drug has been dispensed or the prescription legend drug has been taken for a specified period of time. The quantity or time period used to determine if and when prior authorization will be required will be recommended by the carrier, in accordance with FDA approvals and the manufacturer's recommendations, and approved by the Program Administrator.

Prescription legend drugs requiring predetermination will be covered under the Program if the Pre-determination criteria are met. A prescription legend drug requiring predetermination will not be covered under the Program if 1) the requested clinical information is not provided by either the enrollee or prescriber to the carrier, or 2) the information provided by the enrollee or prescriber to the carrier is insufficient to meet the clinical requirements determined by the carrier in accordance with FDA approvals and the manufacturer's recommendations.

The carrier will periodically make recommendations to remove or add prescription legend drugs to the prior authorization process. A list of those drugs requiring prior authorization will be made available to the enrollee by the carrier upon request.

Adverse determinations made by the carrier under the predetermination process may be appealed by the enrollee according to Article I, Section 6.

6. Limitations and Exclusions

a. Transdermal nicotine patches or any other medication or prescription legend drug used for or in connection with the control or cessation of smoking are covered only if ordered through the Mail Order Prescription Drug program.

Transdermal patches are limited to one continuous 12-week supply, lifetime maximum.

b. Coverage under this subsection does not include:

(1) any research or experimental agent including Federal Food and Drug Administration approved drugs which may

be prescribed for research or experimental treatments;

(2) any charge for a prescription legend drug which requires prior authorization by the carrier for initial or continued coverage, unless such authorization is received;

(3) any charge for a medication being used for a cosmetic purpose, even if the medication is a prescription legend drug;

(4) any prescription legend drug prescribed for the purpose of attempting to induce pregnancy;

(5) any charge for a prescription legend drug prescribed for weight control or appetite suppression;

(6) any charge for devices (other than diaphragms) or appliances (e.g., orthotics, and other non-medical items);

(7) any vaccine administered for the prevention of infectious diseases;

(8) any charge for administration of covered drugs;

(9) any charge for a covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's order;

(10) any charge for more than a 34-day supply of a covered drug provided by a retail pharmacy, or any charge for more than a 90-day supply of a covered drug supplied through the Mail Order Prescription Drug program;

(11) any charge for medications furnished on an inpatient or outpatient basis covered under any other subsection of this Appendix or under any subsection of Appendix B; and

(12) any charge for drugs received prior to the effective date of this coverage.

c. Certain prescription legend drugs are covered at retail, at the applicable 34-day copayment, for an original prescription and two (2) refills; thereafter, they are covered at mail, at the applicable 90-day copayment or at retail subject to a 100% copayment penalty.

The carrier will periodically make recommendations to remove or add prescription legend drugs that are subject to this restriction. A list of those drugs requiring prior authorization will be made available to the enrollee by the carrier upon request.

d. Coverage under this subsection is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

7. Pharmacy Network

a. The carrier will maintain a nationwide limited network of participating retail providers (including local and national pharmacy chains, as appropriate), and a mail order pharmacy. The carrier will select network pharmacies, in part, on access and quality assurance criteria. In contracting with providers, the carrier will assure that the providers fully understand the Program's prescription drug coverage provisions, including eligibility requirements and benefit levels. The carrier will negotiate appropriate fees with participating providers.

b. The carrier will meet standards of quality, service and accessibility (e.g., availability of participating providers within 5 miles of enrollee's residence or closest facility if greater than 5 miles for 90% of enrollees).

c. The carrier will establish uniform pharmacy protocols, pharmacy auditing procedures, drug utilization review processes and all quality assurance procedures.

d. The carrier will monitor network performance and provide aggregate data on a regular basis. Data reports will include, but not be limited to, information such as utilization of services, costs, quality measurements, use of various categories of drugs (e.g., generic, single source, etc.), provider prescribing patterns and patient outcomes.

e. The carrier will be subject to independent audits to assure that quality, service, professional standards and other express commitments are being met.

f. The carrier will make benefit payments to the participating providers or, in the case of services received from non-participating providers, the carrier will make benefit payments to the enrollee or non-participating provider, as appropriate.

g. The carrier will administer Drug Utilization Review (DUR) activities to review whether patients receive appropriate drug therapy as measured against generally accepted pharmaceutical practices. Such DUR incorporates concurrent and retrospective reviews. It also incorporates a voluntary drug formulary and a mandatory program to promote use of generic prescription drugs, where appropriate. In addition, DUR will attempt to identify a variety of critical drug therapy problems such as, but not limited to:

(1) Drug-disease conflicts;
(2) Drug-drug interactions;
(3) Age/gender prescription conflicts;
(4) Over and under utilization;
(5) Allergy alerts;
(6) Therapeutic duplication; and
(7) Early refills.

h. The carrier will provide a comprehensive on-line, point-of-service claims processing system with an electronic telecommunication network that facilitates management of enrollee eligibility verification, formulary information, drug prescribing protocols, drug utilization review, pharmacy reimbursement and possibly expanded patient information, to make informed dispensed decisions.

i. The carrier will conduct pharmacist profiling, and individual intensive education will be completed as necessary.

j. The carrier will conduct physician profiling and will identify physicians who exhibit persistently inappropriate prescribing patterns across their practice. Such physicians will be subject to individual intensive education efforts, as necessary.

k. The carrier will prepare appropriate communications regarding the prescription drug coverage for enrollees, network pharmacies and, as necessary, for prescribing physicians.

l. The carrier will ensure that quality assurance mechanisms will be administered to identify routinely inappropriate drug prescribing that could result in adverse medical outcomes, including hospitalization, by incorporating components such as:
(1) A total quality management (TQM) philosophy;
(2) Rigorous pharmacy management and performance monitoring;
(3) Prescribing physician reeducation, as necessary;
(4) Client specific program performance management;
(5) Patient medication compliance monitoring; and
(6) Outcomes assessment analyses.

H. Hearing Aid Coverage

1. Definitions

For the purposes of this subsection:

a. "physician" means a participating otologist or otolaryngologist who is board certified or eligible for certification in such specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of such license, performs a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

b. "audiologist" means any participating person who (1) possesses a master's or doctorate degree in audiology or speech pathology from an accredited university, (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (3) is qualified in the state in which the service is provided to conduct an audiometric examination and hearing aid evaluation test for the purposes of measuring

hearing acuity and determining and prescribing the type of hearing aid that would best improve the enrollee's loss of hearing acuity. A physician performing the foregoing services shall be deemed an audiologist for purposes of this subsection;

c. "dealer" means any participating person or organization that sells hearing aids prescribed by a physician or audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold;

d. "provider" means a physician, audiologist or dealer;

e. "participating" means having a written agreement with the carrier pursuant to which services or supplies are provided under this subsection (if the carrier does not maintain agreements with such providers, "participating" shall mean any provider approved for reimbursement by the carrier);

f. "hearing aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if necessary;

g. "ear mold" means a device of soft rubber, plastic or a non-allergenic material which may be vented or nonvented that individually is fitted to the external auditory canal and pinna of the enrollee;

h. "audiometric examination" means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

i. "hearing aid evaluation test" means a series of subjective and objective tests by which a physician or audiologist determines which make and model of hearing aid will best compensate for the enrollee's loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visit by the enrollee subsequent to obtaining the hearing aid for an evaluation of its performance and a

determination of its conformity to the prescription;

j. "dispensing fee" means a fee predetermined by the carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear molds, under this subsection;

k. "acquisition cost" means the actual cost to the dealer of the hearing aid.

2. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered hearing aid expenses subject to the provisions below.

a. Charges incurred for audiometric examinations are covered to the extent that these charges are reasonable and customary when performed by a physician or audiologist, but only in conjunction with the most recent medical examination of the ear by a physician.

b. Hearing aid evaluation tests are covered only when indicated by the most recent covered audiometric examination up to $12 ($126 effective October 1, 2004) per test or, if higher, the adjusted maximum determined under subsection e. below.

Hearing aid evaluations performed by a physician or audiologist include the trial and testing of various makes and models of hearing aids to determine which one will best compensate for the loss of hearing acuity.

c. Standard hearing aids are covered if:

(1) they are of the following functional design: in-the-ear, behind-the-ear (including air conduction and bone conduction types) or on-the-body;

(2) they are prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation; and

(3) the hearing aid provided by the dealer is the make and model prescribed by the physician or audiologist and is certified as such by the physician or audiologist. Binaural hearing aids will be provided

only for children under 19 years of age with a hearing loss in both ears. For children 7 years of age and under, replacement ear molds are covered as of January 1, 2004 for:

(a) 4 ear molds per year for children under the age of 3; and

(b) 2 ear molds per year for children ages 3 through 7.

d. In order for the charges for services and supplies described in b. and c. immediately above to be covered under this subsection, for an initial hearing aid, an enrollee must first obtain a medical examination of the ear by a physician. Such examination or such examination in conjunction with the audiometric examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity and, in the case of binaural hearing aids for children, would correct or prevent speech impairment. For enrollees under the age of 18, a medical exam is required each time a hearing aid is covered.

e. The maximum covered expense for a hearing aid evaluation test shall be adjusted on October 1 of each year, based on the percentage increase as of the July levels in the United States Consumer Price Index for the immediately preceding 12 months. The result will be rounded to the nearest dollar.

3. Coverages

The enrollee may obtain audiometric examinations, hearing aid evaluation tests and hearing aids that the provider shall have agreed to furnish enrollees in accordance with the following reimbursement arrangements:

a. for an audiometric examination, the reasonable and customary charge;

b. for hearing aid evaluation tests, the reasonable and customary charge, but not to exceed the amount as provided in subsections H.2.b. and e.; and

c. for covered hearing aids, the acquisition cost and dispensing fee.

If the enrollee requests services or devices from the provider which are not covered under these provisions (e.g., binaural hearing aids for enrollees over 19), the enrollee shall pay the full additional charge.

4. Frequency Limitations

If an enrollee has received an audiometric examination, a hearing aid evaluation test or a hearing aid for which benefits were payable under this subsection, benefits will be payable for each subsequent audiometric examination, hearing aid evaluation test or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric examination, hearing aid evaluation test and hearing aid, respectively, for which benefits were payable under this subsection.

5. Exclusions

Covered hearing aid expenses do not include and no benefits are payable under this Section III.H., for:

a. audiometric examinations by an audiologist for any condition other than loss of hearing acuity;

b. medical or surgical treatment;

c. drugs or other medication;

d. audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Worker's Compensation law;

e. audiometric examinations and hearing aid evaluation tests performed, and hearing aids ordered:

(1) before the enrollee became eligible for coverage; or

(2) after termination of the enrollee's coverage;

f. hearing aids ordered while covered but delivered more than 60 days after termination of coverage;

g. audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;

h. audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;

i. audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including any such services or supplies that are experimental in nature;

j. audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

k. audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the enrollee without cost by compliance with laws or regulations enacted by any Federal, state, municipal or other governmental body;

l. audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefor are payable under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision thereof;

m. replacement of hearing aids that are lost or broken unless at the time of such replacement the enrollee is otherwise eligible under the frequency limitations set forth herein;

n. replacement parts for and repairs of hearing aids;

o. charges incurred by enrollees of a health maintenance organization option;

p. charges for a eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for

one standard, conventional hearing aid (See Subsection H.2.c., above);

q. binaural hearing aids except as provided in this subsection for children under 19 years of age; and

r. charges for a digital-controlled/programmable hearing devices, to the extent the charge for such hearing device exceeds the covered expense for a standard, conventional hearing aid (See Subsection H.2.c., above).

I. Durable Medical Equipment and Prosthetic and Orthotic Appliance Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for the rental or purchase of durable medical equipment and the purchase of prosthetic and orthotic appliances only when the following conditions have been met:

a. the items rented or purchased are basic equipment or appliances or are medically necessary special features which are prescribed by the attending physician and approved by the carrier;

b. the equipment or appliances are prescribed by a physician and the prescription includes a description of the equipment and the reason for use or the diagnosis;

c. for purchased durable medical equipment or prosthetic or orthotic appliances, the order must be placed on or after the effective date and prior to the termination date of the enrollee's coverage in this Program; and

d. for rented durable medical equipment, the rental period is on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

2. Payment of Services

a. The carrier will make payment for the reasonable and customary charge for rental or purchase of durable medical equipment when obtained from a provider other than a hospital or skilled nursing facility. Benefit payments for rental of durable medical equipment shall

not exceed the purchase price of such equipment.

b. The carrier will make payment for the reasonable and customary charge for external prostheses and orthotic appliances.

c. Effective January 1, 1998, a nationwide network was established for the administration of coverages for durable medical equipment and prosthetic and orthotic appliances. No enrollee deductible or copayment is required for covered services received within the national network. For services received outside the network, the enrollee is responsible for any difference between the provider's charge and the reasonable and customary charge.

3. Coverages

a. Process for Updating Coverages

(1) A procedure has been established for the ongoing periodic update of the durable medical equipment and prosthetic and orthotic appliance coverages.

(2) Written notification of changes in Medicare Part B durable medical equipment and prosthetic and orthotic appliance coverages, and other recommendations for coverage changes, will be provided to the Corporation by the Control Plan.

The notifications and recommendations shall include, but not be limited to, the following information:

(a) Quality of care, access and appropriate utilization concerns and proposed actions to resolve such concerns;

(b) Any item(s) being replaced by new item(s), and a plan for discontinuation of coverage for the replaced item(s); and

(c) Positive or negative impact on Program costs.

(3) The Corporation shall review and approve or disapprove the application of Medicare Part B coverage changes or other Control Plan recommendations. If approval is given for a coverage change, an effective date will be established.

(4) The Control Plan will advise appropriate carriers of any changes that are approved through this procedure, the effective dates, and any applicable administrative rules. The local carriers will advise providers.

b. Durable Medical Equipment

(1) Unless otherwise indicated below, the equipment must be an item of durable medical equipment, which meets Program standards including being approved for reimbursement under Medicare Part B or adopted in accordance with the process in subsection 3.a., above, and be appropriate for use in the home.

(2) Durable medical equipment is covered when used in a hospital or skilled nursing facility, or when used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility upon discharge.

(3) When the equipment is rented and the rental period extends beyond the expiration of the original prescription, the physician must recertify, by another prescription, that the equipment continues to be reasonable and medically necessary for the treatment of the illness or injury or to improve the functioning of a malformed body member. If the recertification is not submitted, coverage will cease on the date indicated on the original prescription for duration of need, or 30 days after the date of death, whichever is earlier. Coverage will not be provided for rental charges in excess of the purchase price of the equipment.

(4) When the equipment is purchased, coverage is provided for repairs necessary to restore the equipment to a serviceable

condition. Routine periodic maintenance is not covered.

(5) The following equipment is covered, subject to any stated conditions and to the other Program standards, although not Medicare approved:

(a) neuromuscular stimulators, if prescribed by an orthopedic or physiatric specialist;

(b) positioning transportation chairs as alternatives to traditional wheelchairs for children 14 years of age and under, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders or congenital abnormalities;

(c) external electromagnetic bone growth stimulators, as an alternative to bone grafting in cases of severe physical trauma involving non-union of long bone fractures (in excess of 90 days from the date of fracture), or failed bone fusion (stimulators employed in invasive stimulation are excluded under this subsection I.);

(d) pressure gradient supports (also known as burn pressure garments) prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremity (up to four times annually for chronic conditions unless there is a change in physical conditions such as gain or loss of weight of the patient), or when prescribed to enhance healing and prevent scarring of burn patients;

(e) phototherapy (bilirubin) light with photometer, for patients under the age of one having a diagnosis of hyperbilirubinemia;

(f) special features which, although not subject to review and approval under Medicare Part B, are necessary to adapt otherwise covered equipment for use by children; and

(g) continuous passive motion device for use after surgery to the elbow or shoulder (as well as following total knee replacement, as provided by Medicare).

(6) Pronged and standard canes must be purchased.

c. Prosthetic and Orthotic Appliances

(1) Unless otherwise indicated below, the appliance must be a prosthetic or orthotic device which meets Program standards, including being approved for reimbursement under Medicare Part B or adopted in accordance with the process in subsection 3.a., above.

(a) Coverage for therapeutic shoes prescribed for diabetic enrollees not eligible for Medicare shall be limited to the diagnoses established by the Control Plan.

(b) The following items are covered, subject to any stated conditions and to other provisions of the Program and this subsection, although not Medicare-approved:

(i) any style of orthopedic shoe, in addition to a basic oxford, when the shoe is an integral part of a covered brace;

(ii) all orthopedic shoe inserts, arch supports and shoe modifications used with a shoe that is attached to a covered brace; and

(iii) wigs and appropriate related supplies (stands and tape) are covered for those enrollees suffering hair loss from the effects of chemotherapy, radiation, or other treatments for cancer. For the first purchase of a wig and necessary related supplies coverage will be provided up

to $200. Thereafter, during each subsequent calendar year, coverage will be provided up to $125 towards the purchase of a wig and necessary related supplies.

(2) Coverage is provided for appliances furnished by a fully accredited facility or, with carrier approval, by facilities conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. as a provider for the kind of device supplied. The following appliances may be provided by facilities not accredited by the American Board for Certification in Orthotics and Prosthetics: ocular prostheses; prescription lenses; pacemakers; ostomy sets and accessories; catheterization equipment and urinary sets; prefabricated custom fitted orthotic appliances; artificial ears, noses, and larynxes; external breast prostheses; wigs and related supplies and such other appliances as the carrier may determine.

(3) Coverage includes prosthetic appliances or devices which are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment, as well as external prosthetic or orthotic appliances prescribed by a physician for use outside the hospital.

(4) Coverage for a prosthetic and orthotic appliance includes the replacement, repair, fitting and adjustments of the appliance.

(5) Coverage includes only the first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence, or when customarily used during convalescence from eye surgery.

4. Limitations and Exclusions

a. Durable medical equipment which is not covered includes, but is not limited to:

(1) deluxe equipment such as motor driven wheelchairs and beds, unless medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment (for deluxe equipment or features which are not medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment, benefits are limited to the comparable cost of basic, standard equipment);

(2) comfort, convenience, self-help and environmental items not primarily medical in nature such as, but not limited to, bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, air conditioners, humidifiers, sauna baths, paging systems, intercoms and elevators;

(3) physician's equipment (such as sphygmomanometers and stethoscopes);

(4) exercise and hygienic equipment (such as exercycles, Moore Wheel, bidet, toilet seats and bathtub seats);

(5) experimental, investigational or research equipment; and

(6) home uterine monitoring equipment.

b. Coverage for prosthetic and orthotic appliances does not include:

(1) dental appliances; hearing aids; eyeglasses (except as provided in subsection 3.b.(5) above); or such non-rigid appliances and supplies as elastic stockings, garter belts, corsets or arch supports and corrective footwear unless the footwear is attached to a medically necessary brace and covered under subsection 3.b.(1), above;

(2) foot orthotics or any device used to protect the foot from trauma caused by

gravitational forces or shoe pressure, whether functional, supportive, accommodative or digital in nature, and whether or not custom-molded;

(3) hair pieces or wigs, except as specified in Section III.I.3.c.(1)(b)(iii); or

(4) experimental, investigational or research devices.

J. Hospice Coverage

Hospice coverage, as described below, is available to Basic Medical Plan, Enhanced Medical Plan, Standard Medical Plan, Standard Plus Medical Plan and Point-of-Service option enrollees. It addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility.

1. Definitions

For the purposes of this subsection:

a. "Bereavement counseling" means services provided to the patient's family (or other person caring for the patient at home) after the patient's death.

b. "Care rendered in a nursing home facility with hospice support" means care provided to patients who are medically stable but unable to return home because there is no primary care giver available to care for the patient at home, and the patient cannot self-administer the needed care.

c. "Respite care" means short-term inpatient care provided only when necessary to give relief to family members or other persons caring for the patient at home.

2. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a hospice program only if the following conditions have been met:

a. The hospice program services are received on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

b. The services are provided and billed by a hospice program which meets Program standards and is approved by the local carrier.

c. The enrollee is admitted to the hospice program by order of a physician who certifies that the enrollee requires the type of care available through the hospice and that the enrollee has a life expectancy of six months or less.

d. The enrollee voluntarily elects to participate in the hospice program and agrees to accept the services provided by the hospice program as treatment of the terminal condition.

e. The enrollee has benefit period days available under the hospice benefit period (see App. A, II.B.).

3. Coverages

a. Benefits for hospice services are limited to a maximum aggregate lifetime benefit in accordance with Program standards.

b. Upon admission to an approved hospice program, an enrollee is entitled to receive the following services when rendered as part of the treatment plan:

(1) nursing care provided by or under the supervision of a registered nurse;

(2) medical social services provided by a social worker under the direction of a physician;

(3) physician services;

(4) counseling services provided to the patient, family members and/or other persons caring for the patient at home;

(5) general inpatient care provided in a hospice inpatient unit;

(6) medical appliances and supplies;

(7) physical, occupational and speech therapies;

(8) continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(9) respite care;

(10) bereavement counseling;

(11) care rendered in a nursing home with hospice support; and

(12) home health aide services.

K. Case Management Program

1. Case Management (CM) is a component which is applicable to Basic Medical Plan, Enhanced Medical Plan, Standard Medical Plan, Standard Plus Medical Plan, and POS Plan option enrollees, and which is intended to provide high quality, cost-effective alternative treatment options for patients with catastrophic, chronic, and long-term treatment needs which may result in exhaustion of benefits or high costs. It focuses on those whose care could be maintained, improved or prolonged by more effective use of existing Program provisions or, in appropriate cases, through Alternative Benefit Plans designed to cost no more than the treatment otherwise planned. The Case Management Program is not a method for approving new procedures or services not otherwise covered under the Program.

2. The list of conditions used by the carriers or Utilization Review Organization, as appropriate, for review for potential CM involvement includes, but is not limited to, the following:

a. major head trauma;

b. spinal cord injury;

c. coma;

d. multiple amputations;

e. traumatic and degenerative muscular/neurological disorders (e.g., muscular dystrophy, "Lou Gehrig's Disease," multiple sclerosis);

f. newborns with high risk complications;

g. births with multiple congenital anomalies;

h. cerebrovascular accident (stroke) requiring long-term rehabilitation;

i. severe burns;

j. Acquired Immune Deficiency Syndrome (AIDS);

k. selected blood abnormalities;

l. diagnoses involving long-term IV therapy (e.g., osteomyelitis, pericarditis, endocarditis);

m. severe rheumatoid arthritis;

n. selected osteoarthritis;

o. Crohn's disease; and

p. cases involving extended or repeated hospital stays, as well as cases having multiple admissions for the same diagnosis.

3. Once a patient's medical condition is identified by the carrier or Utilization Review Organization, as appropriate, as having potential for Case Management, the case is reviewed confidentially, and a treatment plan may be developed by the carrier or Utilization Review Organization, as appropriate, with the cooperation of the patient, family, and the physicians/providers.

4. If a decision is made to implement a treatment plan that incorporates services not otherwise covered under this Program (an Alternative Benefit Plan), the remaining days of inpatient care, determined in accordance with the attending physician's prognosis, are converted into a dollar pool against which all benefits paid while the patient is under the Alternative Benefit Plan are charged.

a. The total cost of Alternative Benefit Plans involving services not otherwise covered will be limited by the cost of treatment which would have occurred otherwise.

b. If the dollar pool is exhausted, the Alternative Benefit Plan ceases and the provisions of Appendix A, II.B. will apply with regard to renewal of a benefit period.

c. Participation in Case Management is voluntary, and the patient may withdraw from an Alternative Benefit Plan at any time. In such event, the remaining dollar pool is reconverted to equivalent hospital days to determine the patient's entitlement, if any, remaining in the benefit period.

L. Centers of Excellence

1. Centers of Excellence Program (COE) is a voluntary component applicable to Basic Medical Plan and Enhanced Medical Plan option enrollees who do not have Medicare or another group health care plan as their primary coverage. COE is intended to provide information on and access to high quality facilities which specialize in certain organ transplant, cardiac and cancer procedures. It focuses on certain procedures which have been demonstrated to result in better clinical outcomes when performed in higher volume Centers of Excellence facilities. COE is not a method for approving new procedures or services not otherwise covered under the Program.

2. The organ transplant, cardiac and cancer procedures included in COE will be determined based on their clinical complexity by the Utilization Review Organization. The organ transplant, cardiac and cancer procedures may be updated periodically by the Utilization Review Organization, as appropriate.

3. During the predetermination review of a COE procedure, the Utilization Review Organization will evaluate the case for COE referral. The Utilization Review Organization will consider the patient's medical condition, and the clinical complexity of the COE procedure to make COE referrals as they deem appropriate. Participation in COE is voluntary.

4. If the enrollee is offered and agrees to participate in the COE for covered services, additional coverage may be provided for related travel, meal and lodging expenses of the patient and one caregiver, up to a lifetime maximum of $7,500 per enrollee per condition, in accordance with the following requirements:

a. The enrollee is referred to a COE facility located more than 100 miles from the enrollee's place of residence;

b. Paid receipts and other documentation are provided by the enrollee as required by the Utilization Review Organization; and

c. The reimbursement of travel, meal and lodging expenses is approved by the Utilization Review Organization.

5. If an enrollee is referred to a COE facility which is not a participating facility with their Basic Medical Plan or Enhanced Medical Plan, the facility will be treated as a participating facility for COE services provided.

6. In the Point of Service Plan, coverage for organ transplants is only available through network providers.

M. Disease Management

1. Disease Management (DM) is a voluntary component which is applicable to Basic Medical Plan, Enhanced Medical Plan and Point of Service plan option enrollees who do not have Medicare or another group health care plan as their primary coverage. DM is intended to provide education and support for enrollees with asthma, diabetes and cardiac conditions. It focuses on assisting enrollees to better manage their condition. Disease Management is not a method for approving new procedures or services not otherwise covered under the Program.

2. Except for the Point of Service Plan, if an enrollee is offered and agrees to participate in DM, coverage may be provided for patient education and related services not otherwise covered under this Program in accordance with the following conditions:

a. The services are approved in advance by the carrier or Utilization Review Organization, as appropriate.

b. The services are part of a disease management treatment plan and are focused on the enrollee's asthma, diabetes or cardiac condition.

IV. Limitations and Exclusions

In addition to the limitations and exclusions appearing in other Sections of this Appendix, the following general limitations and exclusions apply to all Sections:

A. Effective date: For the purposes of this Section, effective date means the later of the effective date of this Program or the effective date of the enrollee's coverage under this Program. Benefits are not provided under this Program for:

1. services, treatment, or care provided to an enrollee prior to the effective date; or

2. hospital, skilled nursing facility, or home health care services for admissions which commenced prior to the effective date.

B. Termination date: Coverage is not provided for services provided after the date this Program or an enrollee's coverage under this Program is terminated except that the coverage continues for physician and hospital, skilled nursing facility, or residential substance abuse facility services for continuous predetermined and approved (see App. A, II.A. and App. B, II.A.) inpatient admissions which commenced prior to the termination date of such coverage.

C. Excluded facilities: Coverage under this Appendix does not include services provided by a day or night care program, a halfway house, group home, adult foster care facility, health club or the like.

D. Private duty nursing services: Coverage under this Appendix does not include services of private duty nurses.

E. Room accommodations: If accommodations more expensive than those specified in Section III.A. are used for any reason, the carrier will not pay the difference between the charges for the more expensive accommodations and those for the covered accommodations. If, for any reason, the enrollee occupies accommodations less expensive than those covered by this Appendix, the enrollee is not entitled to payment of the difference in charges.

F. Dental services: Coverage does not include dental services except as specifically provided for in this Appendix.

G. Temporomandibular joint (TMJ) dysfunction: Coverage under this Appendix for diagnosis and treatment of TMJ dysfunction is limited to diagnostic examinations and imaging, surgery to the joint (including related facility charges) and medically necessary post-surgical physical therapy services.

H. Chemotherapy: Coverage does not include chemotherapy services or supplies (chemotherapeutic antineoplastic agents and their administration) when the treatment is research, investigational or experimental in nature or when not specifically provided for in this Appendix.

I. Medical necessity: Coverage does not include services, care, treatment, or supplies which are not medically necessary according to accepted standards of medical practice in the United States for the diagnosis and/or treatment of any condition, injury, disease, or pregnancy, except as specifically provided for in this Appendix (e.g., physical examinations, immunizations, screening tests, contraceptive services and voluntary sterilization's, see App. A.I.R.). Determinations of the Control Plan or Utilization Review Organization, as appropriate, as to medical necessity and the accepted standards of medical practice are based on factors which include, but are not limited to: scientific data (such as reported controlled studies); information from local and national medical, professional and insurance societies, organizations, committees and bodies; and approvals and policies of the Food and Drug Administration, the Department of Health and Human Services and other Federal agencies. The Control Plan or Utilization Review Organization, as appropriate, shall have discretionary authority to interpret, apply and construe this provision of the Program. Their exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

J. Research, investigational or experimental services: Coverage does not include care, services, supplies, or devices ("procedures") which, as determined by the Control Plan, are experimental, research or investigational in nature (i.e., ones, which in the judgment of the Control Plan, have not been demonstrated scientifically to be both effective and safe in the treatment of the patient's condition). This exclusion applies to facility and professional services directly related to non-covered experimental, research or investigational procedures. However, if the Control Plan or Utilization Review Organization, as appropriate, determines that hospitalization is medically necessary and appropriate in order for such non-covered procedure to be performed safely, routine hospital and professional services not related directly to such non-covered procedure may be covered. The Control Plan is responsible for determining whether a procedure is experimental, research or investigational in nature based on factors which include, but are not limited to: the

existence of an experimental, research or investigational plan or protocol; the necessity for written informed consent used by the treating physician (which may or may not include a reference to the procedure being research, investigational, experimental or other than conventional in nature); existence of ongoing clinical trials; scientific data such as controlled studies which are reported in medical literature; approvals and policies of Federal agencies; and information from professional groups. The Control Plan shall have discretionary authority to interpret, construe and apply this provision of the Program. The Control Plan's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious. (See Article I, Section 6 (b) for appeal of a determination that a service, supply device or drug therapy is research, experimental, or investigational in nature.)

Procedures, services, supplies, drugs, products, applications of the above and other items which are considered to be experimental, research or investigational are evolutionary in nature. The Control Plan is responsible for maintaining current information on items which have been so identified for purposes of claims adjudication, and such information is incorporated herein by reference.

The fact that a procedure, service, supply, drug, product, etc., is not so identified shall not in any way infer that it is not experimental, research or investigational in nature. The information is intended to be illustrative rather than exhaustive.

Enrollees and/or providers having questions about the status of items may obtain Control Plan assistance in resolving the questions.

At the point in time when the Control Plan determines a procedure previously identified as experimental, research or investigational has become standard medically accepted practice in the United States, the Control Plan will make a recommendation to the Corporation under the procedure for approval of new services (see App. A, II.I.). If the Control Plan's recommendation is adopted (in its entirety or with modifications), an effective date will be assigned and coverage will be provided on and after that date. If the Control Plan's recommendation is rejected, the procedure will be identified as a specific Program exclusion.

K. Personal or convenience items: Coverage does not include care, services, supplies, or devices which are personal or convenience items. Examples include, but are not limited to, television/telephone rental, guest meals and the like.

L. Services not related to specific diagnosed illness or injury: Coverage does not include services for premarital examinations or pre-employment examinations.

M. Unreasonable charges: Coverage does not include any charges to the extent such charges are determined by the carrier to be unreasonable.

N. Employer related services: Coverage does not include services related to any condition, disease, ailment, or injury arising out of or in the course of employment and for which the employer furnishes, pays for, or provides reimbursement under the provisions of any law of the United States or any state or political subdivision thereof, or for which the employer makes a settlement payment. Coverage does not include services rendered through a medical clinic or other similar facility provided or maintained by an employer.

O. Services available without cost: Coverage does not include services for which a charge would not have been made if no coverage existed; services for which the enrollee is not legally obligated to pay; or services which the enrollee received or, upon application, could receive without cost under the laws or regulations of the United States of America, Dominion of Canada, any other country, or any state or political subdivision thereof.

P. Services available through other programs: Coverage does not include any service to the extent the benefits are payable:

1. Under any group health care contract under the coordination of benefits provision of this Program;

2. Under Medicare, if the enrollee was or would have been eligible for Medicare benefits at the time of service had the enrollee enrolled in Medicare (see App. A, II.E.); or

3. Under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision except where by law this Program is made primary.

Q. Services provided by family members or relatives: Coverage does not include services provided to the

enrollee by members of the enrollee's household or immediate relatives of the enrollee. For purposes of this provision, "immediate relative" refers to the enrollee's spouse, natural or adoptive parents, children or siblings, step-parents, -children or -siblings, father-, mother-, son-, daughter-, brother- or sister-in-law, and grandparents or grandchildren of the enrollee or the enrollee's spouse.

R. Custodial or domiciliary care: Coverage does not include care, services, supplies or devices related to custodial or domiciliary care provided in an institutional setting (e.g., hospital, nursing facility) except as provided under the home health care and hospice provisions of this Appendix (App. A, III.D. and III.J., respectively).

S. Inducement of pregnancy: Coverage does not include care, services, supplies, drugs or devices which are provided for the purpose of inducing pregnancy.

T. Travel: Coverage does not include travel time or expenses.

U. Education: Coverage does not include special education facilities and tutoring for learning disabilities or correction of behavioral problems.

V. Food and dietary supplements: Coverage does not include food/dietary supplements or vitamins.

W. Physician requirements: Coverage does not include services, supplies or equipment not performed by, prescribed by or rendered by a physician.

X. Miscellaneous services: Coverage does not include charges for acupuncture, massage, Christian Science services, hypnotherapy, neurotherapy, or biofeedback therapy or services.

Y. Provider administrative charges: Coverage does not include charges for missed appointments, room or facility reservations or the completion of any claim forms or record processing.

Z. Bone marrow transplants:

1. Allogeneic bone marrow harvesting/transplants

a. Facility and physician services are covered when related to allogeneic bone marrow harvesting and transplants performed to treat the following conditions:

(1) aplastic anemia;

(2) acute lymphocytic and non-lymphocytic leukemia;

(3) chronic myeloid leukemia;

(4) severe combined immune deficiency disease (SCID);

(5) Wiskott-Aldrich syndrome;

(6) osteopetrosis;

(7) beta thalassemia, major;

(8) neuroblastoma (stage III or IV);

(9) Hodgkin's disease (stage III or IV);

(10) non-Hodgkin's lymphoma (intermediate or high grade);

(11) Hurler's syndrome; and

(12) myelodysplastic syndromes.

(13) breast cancer (stage IV);

(14) sickle cell anemia for selected patients;

(15) myelofibrosis;

(16) hematologic malignancies; and

(17) non-malignant bone marrow disorders.

b. Bone marrow transplants are covered when the donor is a first degree relative and has either the same genetic (i.e., human leukocyte antigen or HLA) markers (six out of the six important genetic markers) or at least four out of the six important genetic markers as the person receiving the transplant. When only four or five out of the six genetic markers match, the mixed lymphocyte culture (MLC) must be negative.

c. Also included as covered services are:

(1) bone marrow transplants when the donor is not a first degree relative and has the

same five important genetic markers as the person receiving the transplant;

(2) blood tests on relatives for evaluation as donors, if the tests are not covered by the potential donor's health care coverage;

(3) harvesting of marrow, if not covered by the donor's health care coverage, when the donor is:

(a) a first degree relative with no less than four out of the six important genetic markers as the person receiving the transplant; or

(b) a person other than a first degree relative with the same five out of six important genetic markers as the person receiving the transplant;

(4) search of the National Donor Marrow Program Registry for a donor, and harvesting and transportation of marrow, when the donor is:

(a) a first degree relative with no less than four out of the six important genetic markers as the person receiving the transplant; or

(b) a person other than a first degree relative with the same five out of six important genetic markers as the person receiving the transplant;

provided the Registry's bill must be submitted to the carrier by the bone marrow transplant center.

2. Autologous bone marrow/peripheral stem cell harvesting/transplants

Facility and physician services are covered when related to autologous bone marrow/peripheral stem cell harvesting and transplants performed for the following conditions:

a. Hodgkin's disease (stage III or IV);

b. non-Hodgkin's lymphoma (intermediate or high grade);

c. neuroblastoma (stage III or IV);

d. acute lymphocytic and non-lymphocytic leukemia;

e. germ cell tumors of ovary, testis, mediastinum or retroperitoneum

f. multiple myeloma; and

g. AL amyloidosis.

3. Non-covered expenses

Facility and physician services and other charges directly relating to bone marrow transplants other than those identified in subsections Z.1. and Z.2., above, are excluded. Excluded services and charges include, but are not limited to:

a. bone marrow transplants when the donor is a first degree relative and has less than five out of six genetic markers as the person receiving the transplant;

b. bone marrow transplants when the donor is not a first degree relative and has less than six out of six genetic markers as the person receiving the transplant;

c. autologous bone marrow and/or peripheral stem cell and/or allogeneic bone marrow harvest and transplants for solid tumors other than shown in 1. and 2. above;

d. allogeneic bone marrow transplants for patients with multiple myeloma;

e. search of the National Donor Marrow Program Registry for a donor, other than a first degree relative, with fewer than five out of six important genetic markers as the person receiving the transplant;

f. bone marrow harvesting, storage, transportation or transplantation from a person, other than a first degree relative, with fewer than five out of six important genetic markers as the person receiving the transplant;

g. purging or positive stem cell selection of the bone marrow or peripheral stem cell collection; and

h. travel expenses of patients (other than ambulance services which may be covered under App. A, III.F., in appropriate cases) and family members.

AA. Cochlear implant: Coverage under this Appendix, for services related to the implantation of a cochlear hearing device, is subject to Program standards regarding patient selection, covered pre-surgical, surgical and post-surgical services and covered devices, as well as to a lifetime maximum of one device/implantation for each enrollee satisfying the patient selection criteria.

BB. Services related to corrective eye surgery: Coverage under this Appendix does not include any services, supplies or charges related to corrective eye surgery, as defined in Appendix D, III.K. of this Program. See Appendix D, IV. C. for Program coverage provisions for such surgery.